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Newsletter of the Drug Misuse Research Division

The National Documentation Centre will publish a new edition of *Directory of courses and training programmes on drug misuse in Ireland* early in 2007.

Course co-ordinators who wish to revise an existing entry or include a new course in the 2007 Directory should send us full details on the application form obtainable from mdunne@hrb.ie before 31 January 2007.

→ 2006 European drugs report

→ RDTF strategies – review

→ Ready for Work programme

→ Drug-related public nuisance

→ Dial to Stop Drug Dealing

→ Treatment of problem cocaine use

→ EU survey on AIDS prevention

→ MQI review 2005

Repeat survey of substance use in Cork and Kerry

Dr Tim Jackson, author of *Smoking, alcohol and drug use in Cork and Kerry 2004*

Published in October 2006, *Smoking, Alcohol and Drug Use in Cork and Kerry 2004*[1] reviews substance use in the former Southern Health Board area and compares findings with an earlier study conducted by the same author, Dr Timothy Jackson, in 1996.

The survey was divided into two parts. The first part was administered by an interviewer and covered a number of topics – general views on the respondent's local area, knowledge of specific drugs, usage of tobacco and alcohol, attitudes about drugs and how they should be dealt with in the community, leisure activities and demographic information. The second part was a self-completion questionnaire which related to usage of drugs (including injecting drug use) and personal knowledge of people who had received or might need professional advice for alcohol- or drug-related problems. This article will focus on the findings in relation to alcohol consumption and drug usage. An article examining community perceptions of substance misuse issues will be included in the next issue of *Drugnet Ireland*.

The methodology of the 2004 study was similar to that used in 1996. The survey was a multi-staged, quota-controlled household survey with random starting points. The target population was people living in the three main regions of the former Southern Heath Board (SHB): Cork City, Cork County and Kerry County. The main sample consisted of 1,512 respondents, aged between 15 and 44 years and divided equally between the three regions, with approximately 500 respondents from each region.

In order to boost the number of those involved in substance use detected by the survey, a booster sample was also used. This targeted populations where there was considered to be greater risk of substance misuse. The booster sample consisted of approximately 900 respondents aged between 15 and 24 years from the most deprived urban areas of each region. The only changes to the methodology between 1996 and 2004 were in relation to the booster sample. In order to increase statistical robustness it was increased from 600 to 900 and the areas of deprivation were based on the Small Area Health Research Unit index. The final analysis was based on 1,508 respondents from the main sample and 909 from the booster sample.

The survey found that alcohol remained the dominant substance of misuse in terms of prevalence and problem use. Alcohol consumption was measured in units, where 1 unit is equal to a glass of wine, a measure of spirits or a half pint of beer, cider or alcoholic lemonade. Problem or dependent alcohol use was measured by responses to the four CAGE screening questions (see report for details). Eighty-one per cent of respondents were current drinkers, with the rate for women (79%) almost equal to that for men (82%). The rate of current drinking had increased by 3% since 1996.

Twenty-six per cent of men and 17% of women drank in excess of guidelines. This figure had doubled for women since 1996. Twenty-two per cent of men and 11% of women were CAGE-

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Substance use in Cork and Kerry *(continued)*

positive, indicating problem or dependent use of alcohol. Men drank an average of 18 units and women an average of 9 units per week. This represented a 30% increase in women's weekly consumption compared to 1996. Binge drinking was common for some respondents, with 50% of men and 25% of women reporting that they had drunk to excess three or more times in the previous month.

The percentages of men in each of three categories of problem alcohol use had not changed significantly since 1996, with Category 1 (excessive drinking) at 17%, Category 2 (problem drinking) at 8% and Category 3 (problem and dependent drinking) at 4%. However, women's alcohol consumption had moved into more damaging categories. Those in Category 1 doubled to 13%, Category 2 trebled to 3% and Category 3 increased to 1%. Of the respondents aged under 18 years, 41% (47% of boys and 32% of girls) were current drinkers (a drop of 3%). The proportion of this age group that reported having been drunk (87%) had increased by 15% since 1996.

Drugs were categorised into cannabis, stimulants, opiates, hallucinogens, sedatives and solvents. Drug use was classified according to whether the substance was ever taken (lifetime use), taken in the last year (recent use) or taken in the last month (current use). The use of cannabis (in all forms) had doubled since 1996, with 32% reporting lifetime use, 14% reporting recent use and 7% reporting current use of the drug. The use of stimulants in general and ecstasy in particular had also doubled since the previous survey in terms of both lifetime use (stimulants 10% and ecstasy 7%) and recent use (stimulants 4% and ecstasy 2.5%).

The numbers using cocaine and heroin remained low but there were marked increases in usage of these drugs since 1996. Lifetime use of cocaine increased from 1.1% to 6% and recent use increased from 0.4% to 2.5%. Lifetime use of crack increased from 0.3% to 2%. The author points out that, while the actual prevalence levels are still low, 'the increases show a serious trend'. Lifetime use of opiates doubled to 2% and recent use increased from 0.3% to almost 1%. Lifetime use of heroin increased from 0.2% to 1.6% and recent use increased from 0.2% to 0.5%.

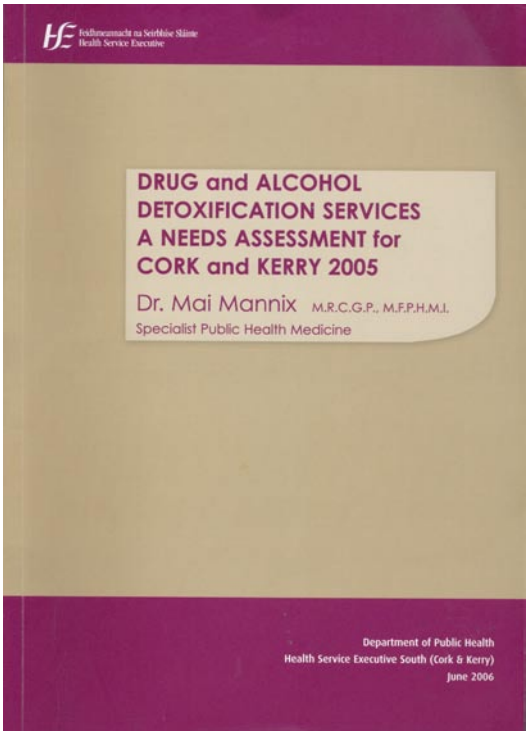
When the three main regions were compared, Cork City showed the highest rates for all modes of drug use. Lifetime use was 41%, compared to 30% elsewhere. Recent use was 18%, compared to 14% in Kerry County and 11% in Cork County. While there were significant increases in all categories of drug use in all three regions, this was particularly true in Cork County and Kerry County where rates of drug use doubled or tripled.

The author compared the study findings in relation to alcohol and drugs with a number of recent studies carried out to estimate substance use in the community. The findings regarding alcohol consumption were consistent with the NACD general population survey 2002/2003, the MWHB Secondary Schools Survey 2002, the European School Survey Project on Alcohol and Other Drugs 2003 and the Health Behaviour in Secondary School Children 2002 study. While the findings in relation to drug use were comparable to many school studies and other population lifestyle studies, overall drug use was much higher than the levels reported in the NACD general population survey 2002/2003. This may be due to methodological differences between the two studies. The NACD survey used direct interviewing throughout, but drug-use data in this study were gathered using a confidential self-completion questionnaire. Research suggests that self-administered questionnaires lead to increased reporting of drug use, especially of stigmatising drugs, while direct interviewing may bias respondents towards what they perceive to be more socially acceptable answers (see report for references). The author stated that the increases in drug use found in this study were reflected in the data on problem drug use in the SHB reported to the National Drug Treatment Reporting System. *(Sarah Fanagan)*

1. Jackson TMR (2006) *Smoking, Alcohol and Drug Use in Cork and Kerry 2004*. Cork: Department of Public Health, HSE South.

Recent use (taken in the last year)	NACD general population survey 2002/2003 %	Southern Health Board (HSE South) 2004 %	Southern Health Board (HSE South) 1996 %
Cannabis	5.0	14.0	6.6
Ecstasy	1.1	2.5	1.9
Cocaine	1.1	2.5	0.4
Crack	0.1	0.8	0.2
Heroin	0.1	0.5	0.2

Drug and alcohol detoxification: a needs assessment for Cork and Kerry



On 4 October 2006, the Health Service Executive (HSE) published an assessment of the need for drug and alcohol detoxification services in counties Cork and Kerry.[1] Dr Mai Mannix, the report's author, presented the main findings at the launch of the report in Cork.

Dr Mannix reviewed data from a number of national databases to determine the numbers treated for drug and alcohol dependence and the medical consequences of drug and alcohol use. She interviewed 17 clinical decision makers from a range of professional backgrounds and one health service manager about their experiences of managing clients requiring detoxification services. Six clients were interviewed about their experiences of being assessed for and undergoing detoxification. She sent 512 questionnaires to doctors (GPs, hospital consultants and psychiatrists) and addiction counsellors in Cork and Kerry. Of these, 316 (62%) completed forms were returned. This questionnaire ascertained the respondents' experiences of detoxification services and their recommendations for the future.

Review of existing data sources

In relation to drug and alcohol use among the population living in Cork and Kerry, a report[2] published on the same day revealed that in 2004 34% of the population aged between 15 and 44 years had ever used a drug; cannabis was the most commonly used drug (32%); and opiates and solvents were used less frequently (2%). According to the 2003 SLAN survey,[3] 21% of the adult population of Cork and Kerry who drank on a weekly basis consumed more than the recommended weekly limit for alcohol. The number of cases who sought treatment for problem alcohol or drug use at the addiction services and were reported to the National Drug Treatment Recording System (NDTRS) increased steadily, from 602 in 1999 to 1,859 in 2002; this was followed by a small decrease to 1,778 in 2003. Alcohol was the main problem substance in approximately two-thirds of the cases reported to the NDTRS. The National Psychiatric In-patient Reporting System recorded approximately 200 new cases treated for problem alcohol use in psychiatric units in the region each year between 2000 and 2002, while an annual average of 35 new cases were treated for drug dependence during the same period. The Central Treatment List reported that 38 persons with addresses in counties Cork or Kerry received methadone treatment during 2004; the small number of cases may have been due to a lack of treatment availability rather than to a low level of demand.

The medical consequences of drug and alcohol use in Cork and Kerry were measured by reference to drug- and alcohol-related admissions to acute hospitals and death notifications. There was a notable increase in alcohol-related admissions to acute hospitals in the region, from 1,634 in 1999 to 2,360 in 2001. The number of drug-related admissions to acute hospitals remained relatively stable at around 55 per year during the same period. There were 25 direct alcohol-related deaths and 55 direct drug-related deaths in the region in the period 2001 to 2003. Between 1995 and 2001, the rate of deaths from chronic liver disease and cirrhosis of the liver (conditions associated with high levels of alcohol consumption) increased annually in Cork and remained relatively stable in Kerry.

Detoxification requirements

Dr Mannix reported an increase in the number of addiction services providing treatment for problem drug and alcohol use, from three in 1999 to 10 in 2003. She noted that, although a number of databases held data on alcohol and drug dependence, little information was available on the number of detoxifications provided to those treated. (Up until 2004, the type of substance was not specified in cases of detoxification reported to the NDTRS.) Using data from an area in the United Kingdom and a model developed by a Canadian researcher, Dr Mannix estimated that 611 people living in Cork and Kerry would require detoxification from alcohol each year, 55 of them on an inpatient basis.

There was a notable increase in alcohol-related admissions to acute hospitals in the region, from 1,634 in 1999 to 2,360 in 2001.

Drug and alcohol detoxification *(continued)*

In-depth interviews

The key decision makers interviewed had experience in providing detoxification services in either a community or an inpatient setting. They reported that there was a need for a consultant psychiatrist specialising in addiction to lead the service. They said that a dedicated inpatient service was required in the region, and that general practitioners should be facilitated in providing additional outpatient detoxifications. They felt that services were required for people with drug and alcohol problems who were homeless, and that liaison workers were required to link detoxification with medication-free therapy and aftercare. The key decision makers were reluctant to develop a service for opiate users.

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The health service users interviewed reported that outpatient detoxification was available from general practitioners but that inpatient detoxification could be difficult to access. They agreed with the key decision makers that additional inpatient detoxification services were required.

Postal survey

The survey of health service providers in the region revealed that all the psychiatrists and three-fifths of the general practitioners provided a detoxification service. The average number of detoxifications was 33 per year by psychiatrists and six per year by general practitioners. These were mainly detoxifications from alcohol, although 60% of psychiatrists and 30% of general practitioners had provided detoxifications from drugs (mainly hypnotic and sedative-type drugs) in the recent past. While almost three-quarters had referred clients to a service outside their own service, 65% reported difficulty in accessing other services, most notably the inpatient psychiatric service. Just 71% had access to aftercare services for clients who had had a successful detoxification. With the exception of the psychiatrists, all service providers were dissatisfied with current service provision in the region. The majority recommended setting up a special detoxification unit, the employment of a consultant psychiatrist specialising in addiction to lead the service, and the expansion of general practitioners' formal involvement in the service. The vast majority agreed that addiction counsellors should provide the link between detoxification and medication-free therapy or aftercare. These recommendations were in line with those of the key decision makers.

Both the service providers and the key decision makers were reluctant to develop a service for opiate users in Cork and Kerry; this is possibly due to a lack of expertise in dealing with opiate-dependent clients. *(Jean Long)*

1. Mannix M (2006) *Drug and alcohol detoxification services: a needs assessment for Cork and Kerry 2005*. Cork: Health Service Executive South.

2. Jackson T (2006) *Smoking, alcohol and drug use in Cork and Kerry 2004*. Cork: Health Service Executive South.

3. Centre for Health Promotion Studies, NUIG (2003) *Survey of lifestyles, attitudes and nutrition (SLAN) and the Irish health behaviour in school-aged children (HBSC) survey*. Dublin: Department of Health and Children.

The State Laboratory Annual Report 2005

The State Laboratory relocated from Abbotstown in County Dublin to Celbridge in County Kildare in May 2005. Its annual report for 2005 was released in October 2006.[1] Under its customer charter, the State Laboratory is committed to providing a top-quality analytical and advisory service for its customers in an efficient and effective manner. Analysis is the core business of the laboratory.

The Human Toxicology Section of the Laboratory provides analytical support for coroners' investigations. This involves analysing post-mortem samples from autopsiesto assist in establishing the cause of death. Information provided can indicate whether the deceased was taking medication at the time of death, if a drug overdose was taken, or if the deceased was under the influence of alcohol or drugs at the time of death.

This Human Toxicology Section also analyses biological samples pertaining to criminal investigations. Samples frequently require a variety of analyses in order to identify different drugs present. Specific analyses are available for illicit drugs, such as cocaine, ecstasy, opiates and cannabinoids. These drugs can be quantified and confirmed to a level that will satisfy the scrutiny of a court of law. A total of 2,311 samples were analysed during 2005. Illicit or abused drugs were present in 81% of these samples, of which 55% showed the presence of an opiate. Cocaine and amphetamine, including ecstasy, were present in 16% of the samples and cannabinoids were present in 13% of the samples. *(Ena Lynn)*

The State Laboratory website is at www.statelab.ie

1. The State Laboratory (2006) *Annual Report 2005*. Dublin: Brunswick Press Ltd.

2006 European report on the drugs problem

The latest facts and figures on drug use across Europe, and by country, are contained in the 11th annual report of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) launched on 24 November. The report includes information on the situation in Ireland provided by the Drug Misuse Research Division of the Health Research Board (HRB), which is the Irish national focal point for the EMCDDA. The report points to an increase in cocaine use, as evidenced by a rise in the numbers receiving treatment for cocaine use and in the number of prosecutions for possession of the drug. There is also evidence of changing patterns in drug use by females.

Cocaine

Figures from the National Advisory Committee on Drugs (NACD) 2002/2003 general population survey show that 3% of the 4,918 respondents had used some form of cocaine at least once in their lives, with just over 1% having used cocaine in the last year (recent use). The proportions of the general population reporting cocaine use in 2002/2003 were similar to the European averages. The number of cases entering treatment and reporting cocaine as their main problem drug increased from 86 in 1998 to 352 in 2004. This figure represents 8% of the total number of cases entering treatment for drug use, which puts Ireland just below the European average of 12%. In 2005, cocaine-related prosecutions accounted for just under 13% of the total, surpassing heroin-related prosecutions (11%) for the first time. The available data from An Garda Síochána and Customs suggest a significant increase in cocaine trafficking in Ireland in recent years. The Garda National Drugs Unit also reports a fall in the price of cocaine per gram.

Drug supply

There has been a fall in the price of illicit drugs across Europe over the past five years. In Ireland, although there is evidence that the prices of ecstasy and cocaine have decreased over the last decade, the absence of a standardised method of monitoring current drug prices or trends over time makes it difficult to comment authoritatively in this area. The EMCDDA reports upward trends in heroin and cocaine seizures in most of Europe. Cannabis seizures account for the vast majority of all drugs seized in Ireland. The total quantity of heroin seized in Europe increased steadily since 1999, and in 2004 reached a record level, up 10% on the previous year. Since 2001, the annual number of heroin seizures in Ireland has remained relatively stable at around 700 seizures. In 2005, 725 seizures were reported. The EMCDDA reports that there has been an increase over the last five years in the number and quantity of cocaine seizures and this is also true in Ireland.

Injecting drug use and blood-borne viruses

Of the 3,403 cases entering treatment in 2004 who reported an opiate as one of their problem drugs, and who had their injecting status recorded, 74% had ever injected and 37% had injected in the month prior to treatment. According to data from prevalence studies, around one-tenth of injecting drug users in drug treatment are HIV positive. By European standards, Ireland is categorised as medium-prevalence in terms of HIV (with a HIV prevalence rate between 5% and 10% among injecting drug users). Data from the Health Protection Surveillance Centre indicate a fall in the number of newly diagnosed HIV cases among injecting drug users between 1994 and 1998. Annual averages indicate a true increase in the number of HIV cases among injecting drug users since 1999. The results of prevalence studies indicate that around 70% of injecting drug users attending drug treatment tested positive for antibodies to the hepatitis C virus. By European standards, Ireland is defined as high-prevalence in terms of hepatitis C (with a hepatitis C prevalence rate over 60% among injecting drug users).

Drug-related deaths

Direct-drug-related deaths are those occurring as a result of overdose. According to data from the General Mortality Register, there was a substantial increase in the number of drug-related deaths between 1995 and 1999, followed by a considerable decline between 2000 and 2002. This decline is in line with trends in drug-related deaths throughout Europe. In 2003, the number of drug-related deaths outside Dublin exceeded for the first time the number of drug-related deaths in Dublin. The data for outside Dublin follow trends in problem opiate use in that geographical area.

Gender

As in Europe, in terms of lifetime prevalence, almost twice as many men in Ireland (24%) as women (13%) reported ever using an illegal drug. However, the number of school-going girls who had ever used cannabis increased by 10%, from 29% in 1999 to 39% in 2003. The corresponding increase for boys was 3%. Of the 4,671 cases entering treatment in 2004, 1,212 (26%) were female. The European average rate for female cases treated was 20%. Since 1999 a specialised service for pregnant drug users has been provided through a drug-liaison midwife at each of the three Dublin maternity hospitals. These midwives have formal links to community-based addiction centres. There was a steady increase in the number of drug-related deaths among women, from one in 1994 to 28 in 2000, and a levelling off in 2001 (at 25) and a small decrease in 2002 (to 21) and a small increase (to 28) in 2003. *(Brian Galvin)*

For a copy of the *EMCDDA Annual Report 2006* and related press material, log on to the EMCDDA website at www.emcdda.europa.eu The DMRD media briefing on the report is on the HRB website at www.hrb.ie

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central reference point for drug information in the EU. Its role is to provide the EU and its member states with objective, reliable and comparable information on drugs and drug addiction. The main information sources for the EMCDDA are the national focal points set up in each EU member state and in Norway.

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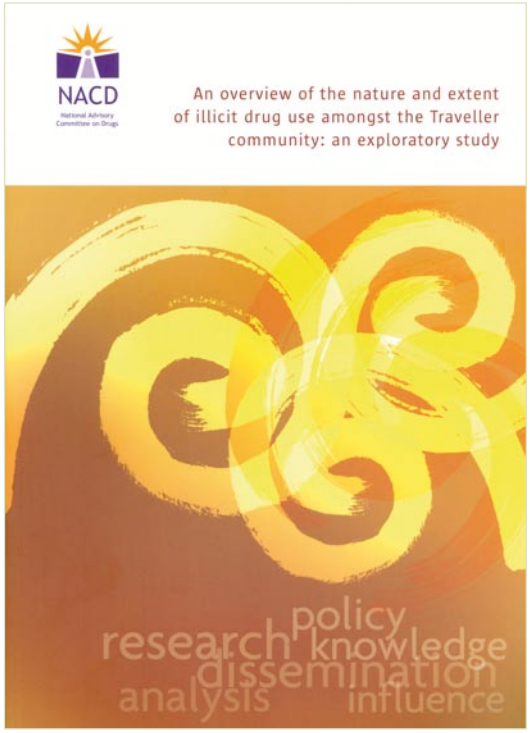
Illicit drug use in the Traveller community



The Traveller community, like other socially excluded populations, is vulnerable to problematic drug use.

Professor Jane Fountain of the University of Central Lancashire assessed the nature and extent of illicit drug use in the Traveller community in Ireland. The report was commissioned by the National Advisory Committee on Drugs and launched in October 2006.[1]

The report provides data on drug use, the patterns of drug use, problematic drug use, drug-related risk behaviours, the effect of drug use on the Traveller community and gaps in service provision. The data-collection techniques included a comprehensive review of the literature, interviews with 34 agency staff, focus groups with 122 Travellers and one-to-one interviews with 15 Travellers who were using or had used drugs. The data were analysed thematically using a grounded theory approach.

According to this report, it is estimated that there are 30,000 Travellers in Ireland and a further 15,000 in the UK. Many of those living in the UK travel between there and Ireland on a regular basis. Travellers have their own language and distinct culture, with a unique value system and specific customs and traditions. Successive governments have introduced legislation and policies to protect the rights of Travellers, but many of these are not implemented in a systematic way throughout the country. Travellers continue to experience discrimination and marginalisation. The author reported that they are socially excluded and do not have equal access to education, health care, employment or accommodation. Traveller children are six times more likely to be cared for by local authorities than children in the general population.

The Traveller community, like other socially excluded populations, is vulnerable to problematic drug use.

As the author notes, the 2002/2003 national survey of drug use in the general population[2] did not record ethnicity, and nor does the National Drug Treatment Reporting System (NDTRS). Consequently, there are no reliable estimates of either drug use or treated problem drug use among the Traveller population. Following requests from some of the addiction service managers, the NDTRS will introduce a system to identify the number of Irish Travellers seeking treatment from 2007 onwards.

Qualitative research indicates that cannabis, sedatives, tranquillisers and antidepressants are the drugs most commonly used in the Traveller community. These are followed by cocaine and, to a lesser extent, ecstasy. These findings mirror the pattern of drug use in the general population. In addition, the Traveller population reported occasional use of amphetamines. The less common substances used by Travellers were heroin, crack cocaine, LSD and solvents, again mirroring the pattern in the general population. Injecting drug use among the Traveller community was not commonly reported. As in the general population survey, more male than female Travellers used drugs, and those in the age range between adolescence and early thirties were more likely to be users. The impact of drug use on Traveller users included poor personal health, involvement in criminal activity, exclusion from the family and the broader community, and stigmatisation. Members of the drug user's family were likely to suffer from stress.

The Travellers interviewed described some of the ways their community dealt with drug use, including home detoxification, avoiding drug-using friends, promising a priest not to use any more drugs and seeking treatment. The author reported that formal treatment was rarely sought. There was no consensus on how to deal with drug dealing in the Traveller community and it was reported that the gardaí were reluctant to tackle the issue. There was evidence throughout the research findings that there was a lack of knowledge about drugs and drug use among Travellers. There are a number of barriers to accessing drug treatment services: lack of awareness of such services, lack of formal education, stigma and embarrassment, lack of cultural competence among service providers and perceptions of racism within services.

The key recommendations of the report were:

- Develop procedures on ethnic monitoring.
- Carry out equality proofing of policies and procedures in social, health and drug-related

services.

- Increase awareness of drugs and drug use among Travellers using appropriate methods.
- Adapt the existing drug services so that Travellers can access them.
- Implement a process to engage the Traveller community in addressing drug use.
- Conduct further research.

(Jean Long)

1. Fountain J (2006) *An overview of the nature and extent of illicit drug use amongst the Traveller Community: an exploratory study*. Dublin: Stationery Office.
2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey. Health Board (Ireland and Health and Social Services Board (Northern Ireland) results (revised)*. Bulletin 2. Dublin: NACD.

Drugs and Diversity seminar

This seminar, hosted by Merchants Quay Ireland and Pavee Point, explored issues identified in two recent studies dealing with drug use among members of new communities in Ireland and among Travellers.[1,2] The authors of the two reports, Caroline Corr of the Combat Poverty Agency and Professor Jane Fountain, University of Central Lancashire, presented their findings. Mr Manjit Singh Johal, Service User Involvement & Advocacy Officer, Derbyshire Drug and Alcohol Addiction Team, and Mr Yaser Mir of the Centre for Ethnicity and Health, University of Central Lancashire, also spoke to the seminar. The seminar was held in Dublin on 2 November and was attended by delegates from several statutory, community and voluntary organisations and NGOs. *(Brian Galvin)*

1. Corr C (2004) *Drug use amongst new communities in Ireland: an exploratory study*. Dublin: National Advisory Committee on Drugs.
2. Fountain J (2006) *An overview of the nature and extent of illicit drug use amongst the Traveller community: an exploratory study*. Dublin: Stationery Office

Yaser Mir, Centre for Ethnicity and Health, University of Central Lancashire

Emma Kennedy, TSDI Pavee Point; Philip Watt, Director NCCRI; Lambert Oliput, Chair of NeCoDrA

Responding to open drug scenes and drug-related public nuisance: towards a partnership approach

A central concern is the idea of the public being confronted in their day-to-day lives with open drug dealing and drug use.

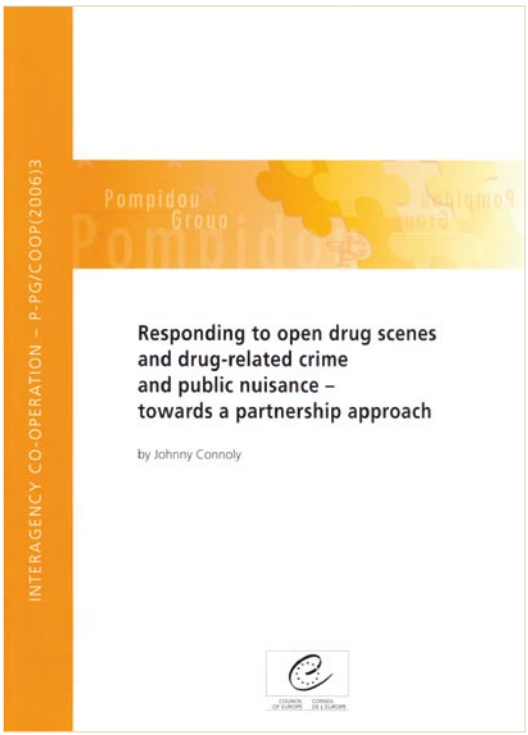
there is a growing consensus that partnership working offers the most sustainable method of responding to many drug problems

Although problems associated with open drug scenes are not new, we have witnessed a greater level of public concern, debate and analysis of such issues at the national and international levels in recent times.[1,2] A Council of Europe report[3] on the issue provides an overview of the hearings of the Pompidou Group Criminal Justice Platform between 2004 and 2006. During this period, the Platform convened five meetings on the topic and heard presentations from 30 cities throughout the European Union and beyond.[4]

A central concern is the idea of the public being confronted in their day-to-day lives with open drug dealing and drug use. The genesis and scale of the problems experienced vary from place to place. The size of the drug scene can also vary greatly, from small isolated pockets of individuals to scenes with thousands of participants. This can also be affected by the duration of the drug scene and the way in which such scenes can exercise a 'pull-effect', attracting drug users or 'drug tourists' from other cities or countries. Drug scenes can also attract people who are not primarily looking for drugs but are engaging in other activities that may be associated with the drug scene, such as prostitution. Included among the problems and activities associated with open drug scenes are the following:

> Drug-related mortality; Involvement of organised crime groups; Violence and gang turf wars; Drug-related petty crime in surrounding vicinity; Prostitution; Visible drug intoxication; Visible drug use and injecting; The discarding of needles and other drug paraphernalia; Drug tourism; Emergence of houses where drugs are sold and/or used – 'Crack' houses; Development of a poly-drug market; Open drug scenes can make it difficult for drug users to address their addiction due to visible temptation; Creation of 'no-go' areas for local residents due to fear; Contribution to stigmatisation of local community; Street homelessness; Noise pollution; Attraction of young people to the drug scene; Interference with traffic on roads adjacent to the drug scene.

Most countries have acknowledged that the complexity of the various problems which arise in this context require an equally sophisticated response. Motivated by a concern to balance the general welfare of the broader community with the safety and health of drug users, contemporary approaches seek new and innovative ways of dealing with these old problems. Strategic thinking, in-depth problem analysis, long-term planning and partnership between agencies and stakeholders



are characteristic of this new development. This represents a movement away from reactions based primarily on repression and strict law enforcement. Such partnership approaches, often involving collaboration between law enforcement, social and health services and other stakeholders including local communities, have faced their own obstacles and challenges. Nevertheless, there is a growing consensus that partnership working offers the most sustainable method of responding to many drug problems.

Many of the practical examples of partnership presented to the Criminal Justice Platform combine elements both of tolerance and repression and therefore they do not lend themselves to typical categorisation as either repressive or liberal. This can be as a result of the need to find, within a particular local context, a compromise between pressure groups. At given times a repressive approach can dominate the response, for example, where open drug scenes expand to unmanageable proportions or when related crime and nuisance levels attract media attention and/or lead to demands from local residents, business interest groups or politicians for swift action. Opposition of this nature can lead to the mobilisation of local residents' groups or intensive policing aimed at removing the open drug scene. However, the experience in many countries is that such action, while understandable from the perspective of the local pressure group perhaps, is a short-term

response which generally only serves to displace the drug scene to a different residential location, or to a public place such as a train station. Furthermore, the drug scene is often driven underground and, while the nuisance concerns of the local public may have been addressed, the health predicament of drug users can deteriorate as they become invisible and inaccessible to harm reduction measures, drug treatment and social and health services. In some experiences, the repression and dispersal of 'open drug scenes' has been associated with increases in drug-related deaths and other drug-related harms. Also, the removal of open drug markets through intensive law enforcement can lead to adaptation by drug dealers and the development of more closed markets, based in local houses, facilitated by mobile phones for example and increasingly impenetrable to police or other services.

Partnership working has raised a number of challenges for stakeholders. Policing authorities have had to acknowledge that their response must move beyond strict law enforcement and towards more problem-oriented policing. On the other hand, social care personnel are challenged to accept that there is a role for law enforcement, particularly in terms of addressing the concerns of the wider public with regard to drug-related nuisance. For local residents, accepting the establishment of drug treatment facilities close to their homes has been a contentious issue.

Addressing and overcoming community fears or tackling traditional professional and cultural assumptions by agency personnel form an important component of the overall challenge of partnership working. The ability to overcome such challenges is dependent upon a range of factors. Among the most important of these is the infrastructure of partnership; that is the coordinating, decision-making and communication systems agreed by the various stakeholders to facilitate their collaboration. Based on the experiences presented to the Criminal Justice Platform, and to inform future partnership initiatives, the report concludes by identifying a series of common principles of partnership and a number of good practice guidelines. The guidelines cover the following areas: Problem analysis and planning; Partnership structure and coordination; Communications; Trust and conflict; Training and education; Recruitment and status of partnership.

In September 2006, a conference on drugs was organised as part of Finland's presidency of the European Union. The focus of the conference was the issue of inter-agency cooperation in response to drug-related issues.[5] One of the outcomes of the conference was the agreement to create an international network of partnerships. The Council of Europe's Pompidou Group is to shortly take on the task of creating and co-ordinating such a network. *(Johnny Connolly)*

A copy of the report can be obtained from the National Documentation Centre at http://www.ndc.hrb.ie/attached/2993-RespondingToOpenDrugScenes.pdf

For local residents, accepting the establishment of drug treatment facilities close to their homes has been a contentious issue.

1. EMCDDA (2005) Drug-related public nuisance – trends in policy and preventive measures. In *Annual Report 2005: Selected issues*. Luxembourg: Office for Official Publications of the European Communities.
2. International Narcotics Control Board (INCB) (2004) *Report 2003*. New York: United Nations Publications.
3. Connolly J (2006) *Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach*. Strasbourg: Pompidou Group, Council of Europe.
4. Copies of the individual presentations will be published by the Council of Europe in due course.
5. The report of the conference can be found at http://www.stm.fi/Resource.phx/eng/subjt/inter/eu2006/drugs/drugs1.htx

EU considers economic impact of alcohol policies

The European Commission has issued a Communication[1] outlining a comprehensive strategy to support member states in combating the harmful effects of alcohol use in the European Union (EU), especially among young people. In preparing the Communication, the Commission asked RAND Europe to conduct an assessment of the economic impacts of EU alcohol policies. The resulting document, *An ex ante assessment of the economic impacts of EU alcohol policies*,[2] was published in August 2006. The main objectives of this report were:

- to assess the current macroeconomic impacts of alcohol use and the likely future macroeconomic impacts of the policy; and
- to assess the current economic contribution of the alcohol industry and the likely impacts of the proposed policy on the industry.

Alcohol consumption is associated with many harmful health, social and economic consequences throughout the EU. Fifteen per cent of Europeans (58 million adults) consume harmful or hazardous levels of alcohol. Alcohol is responsible for 11% of

Fifteen per cent of Europeans (58 million adults) consume harmful or hazardous levels of alcohol.

Economic impact of alcohol policies *(continued)*

It is estimated that the tangible cost of alcohol-related harm in the EU in 2003 was €125 billion

premature death and disability among males. It is now the third leading risk factor for the EU disease burden, after tobacco and obesity. Drunkenness and binge drinking among young people are becoming more widespread. Among 15–16-year-olds, binge drinking occurs frequently and 25% of all alcohol-attributable deaths in the EU occur in the 15–29-year age group. It is estimated that the tangible cost of alcohol-related harm in the EU in 2003 was €125 billion, accounted for by health care costs, crime, traffic accidents, lost productivity and premature mortality. This figure does not include intangible costs, which incorporate the value people place on pain, suffering and loss of life that occur due to the criminal, social and health harms caused by alcohol. These costs are estimated to be in excess of €270 billion.

Although the cost of alcohol to European society is substantial, the economic role of the industry in many European countries is considerable. Alcohol accounts for 13.9% of total expenditure on foodstuffs and 1.6% of overall consumer expenditure. It is estimated that alcohol contributes approximately €45 billion and 1.2 million jobs (not including those in the catering industry) to the economy of the EU. In Ireland, alcohol comprises 1.3% of the total value of exports and generated a positive trade balance of €513 million in 2004.

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It is recognised that the effectiveness of harm-reduction policy depends on the prevalence of harmful alcohol use. In populations with a high prevalence of heavy drinking, taxation is the most cost-effective approach, whereas targeted strategies, such as brief interventions at primary care level, random breath testing, or advertising bans, are most cost-effective in populations with a low prevalence. Increases in excise duties are associated with only modest decreases in overall alcohol consumption but there is evidence to suggest that they are very effective in the case of heavy drinkers and young drinkers.

The report outlined four options for future alcohol policy identified by the Commission (p. xiv):

1. **No change:** Policy decisions and initiatives will be left largely to Member States and stakeholders, while the EU continues to finance projects and networks, support research, facilitate exchange of best practice, and collect and disseminate information on alcohol consumption and harm, but does not coordinate activities across policy domains.

2. **Coordination of activities at EU level:** this is similar to option 1, but the EU would encourage stakeholders throughout the EU region to undertake similar activities (e.g. self-regulation, common codes of conduct on commercial communication, exchange of best practice on interventions) and to hold Member States to their Treaty obligations.

3. **A comprehensive strategy:** Application of a wide variety of policy instruments (legislation, self-regulation, information and education campaigns, exchange of best practice, stakeholder involvement) across all relevant policy domains (internal market, taxation, transport, education, research and consumer policy). The strategy would focus on drink-driving, co-ordinated campaigns, protection of third parties, commercial communication, consumer information and availability and prices.

4. **Purely regulatory:** Focus on the use of the policy instrument of regulation to achieve a decline in the harmful effects of alcohol use.

Following evaluation of each option, the authors suggested that options one and two would not result in a decline in the harmful effects of alcohol use. They found that option three was potentially the most efficient and effective approach as it combined policies intended to lower alcohol use with activities targeting the behavioural foundations of harmful drinking. Option four would lower alcohol use through stricter regulation and enforcement, and presented a number of advantages with respect to drink-driving, health care and public revenues. This option was the one most likely to harm the alcohol industry and its supplying industries. Its main disadvantage was that, without a supporting information and education campaign, changes in use might not become engrained in consumer behaviour.

The main conclusion of this report was that a European alcohol policy based on option three represented the preferred choice. By combining a wide variety of policy instruments, this option targeted the behavioural foundations of harmful drinking as well as lowering alcohol use by reinforcing cost-effective regulation and enforcement measures. *(Deirdre Mongan)*

1. Directorate-General Health and Consumer Protection (2006) *An EU strategy to support member states in reducing alcohol related harm.* COM/2006/0625 final. Brussels: Commission of the European Communities.

2. Horlings E and Scoggins A (2006) *An ex ante assessment of the economic impacts of EU alcohol policies*. A technical report for the European Commission. Cambridge, UK: RAND Europe.

RDTF strategies push out the boundaries

By mid-2005, all 10 regional drugs task forces (RDTFs) had submitted their first strategic and/or action plans to the National Drugs Strategy Team for approval (see Table 1).[1] Aligned with, and intended to contribute to the achievement of the overall aims of the National Drugs Strategy, and the objectives and actions under the four pillars, these regional strategies also highlight additional policy concerns, a selection of which is noted below.

Table 1 Regional drugs task forces and catchment areas

Regional drugs task force	Catchment area
East Coast	South Dublin City and County excluding seven LDTF areas, East Wicklow
Midland	Counties Laois, Longford, Offaly, Westmeath
Mid-Western	Counties Clare, Limerick, North Tipperary
North Dublin City and County	North Dublin City and County excluding five LDTF areas
North East	Counties Cavan, Louth, Meath, Monaghan
North West	Counties Donegal, Leitrim, Sligo and north-west Cavan
Southern	Counties Cork, Kerry
South East	Counties Carlow, Kilkenny, South Tipperary, Waterford, Wexford
South West	South and West Dublin, West Wicklow and County Kildare
Western	Counties Galway, Mayo, Roscommon

While the National Drugs Strategy focuses entirely on illicit drugs, calling simply for 'complementarity' between illicit drugs and alcohol policies, the majority of the RDTF strategies address both **alcohol and drugs misuse**. A variety of reasons is given – because alcohol is the biggest problem drug; because alcohol is a bigger problem than drugs, and given the 'deregulation' of the sale of alcohol, treatment service provision needs to be funded as a priority; because polydrug use, including alcohol misuse, is prominent among young people using drugs and the alcohol and drug cultures are intertwined and need to be addressed as part of an inclusive approach. One plan calls for a co-ordinated approach between issues to deal with illicit drug abuse and alcohol abuse but only among teenagers, on the basis that alcohol is not an illicit drug for adults. Two plans, neither of which address the problem of alcohol misuse at all, call for the omission of alcohol from the terms of reference for the RDTFs to be reconsidered by the government.

Alcohol-related supply reduction or control measures identified in the RDTF plans include more regulation of off-licences and supermarkets, introduction of a responsible sale of alcohol programme, opposition to 'happy hours' and alcohol promoting events, and rigorous enforcement of the law in relation to alcohol. Prevention measures include health promotion campaigns to ensure public awareness of alcohol and related issues, and early health promotion interventions to curb the sale of alcohol to under-age young people. Treatment measures include the use of validated screening tools, brief interventions for people with problem alcohol use or alcohol dependence, counselling, and community-based alcohol detoxification services.

The **urban versus rural location of drug misusers** presents a number of challenges not addressed by the National Drugs Strategy but, hardly surprisingly, the matter is raised by a number of RDTFs. With regard to the supply and control of drug markets, concerns are voiced about the nature of links and movements between urban areas and their rural hinterlands. In relation to drug-related treatment services, it is pointed out that urban areas may have a critical mass of service users concentrated in the one locality, resulting in economies of scale for service provision and ease of access for users; in rural areas, however, potential service users may be widely scattered in small villages or remote areas, without easy access to transport. This poses logistical and social challenges in terms of providing services that are both accessible to users, (either by offering transport to larger centres or through providing services locally), and also discrete, (in order to minimise the risk of stigma attaching to those seen attending the service).

In line with the National Drugs Strategy, the RDTFs acknowledge **social inclusion** as the policy framework within which their strategies and actions are set. The Western RDTF strategy document devotes a whole chapter to social inclusion. It describes the nature of the linkage between drugs and social exclusion – 'Poverty

the majority of the RDTF strategies address both alcohol and drugs misuse

RDTF strategies *(continued)*

It has been suggested that filtering drug policies through a social exclusion policy framework may not directly benefit drug misusers

and deprivation are more likely to encourage than discourage drug use, and substance misuse can be both cause and effect of social exclusion'[2] – and discusses the needs of specific socially-excluded groups, including those living in remote rural areas or in socially disadvantaged areas, the homeless, Travellers, and prisoners. It also identifies several tailored service developments to weaken the link between the socially excluded and illicit drugs, including assertive outreach initiatives, decentralised mechanisms that reach to the heart of rural areas, and focusing on outcomes for socially excluded target groups and working to solve the full range of their problems, including substance misuse, in an integrated fashion.

Recent commentators in the UK have problematised the concept of social exclusion. It has been found difficult to test the concept empirically, i.e. to find evidence of social exclusion as distinct from social or economic deprivation, and it has been argued that the concept has served to mask the inequalities and conflicts of interest said to be inherent in market-based societies and to affect a much larger cross-section than those categorised as 'socially excluded'.[3] The relationship between social exclusion policy and the drugs issue has also been questioned. It has been suggested that filtering drug policies through a social exclusion policy framework may not directly benefit drug misusers: 'allowing a social exclusion agenda to determine our drug policies will skew services heavily towards those that attempt to prevent crime, reassure the frightened and promote employment – that is, away from those that prioritize the complex needs of people who are actually addicted.'[4]

As an alternative to social inclusion, the Southern RDTF has based its strategic plan within an **equality** framework. Its assessment of the drugs and alcohol situation in the southern region is organised around consideration of seven of the nine grounds specified in Ireland's Equal Status Act 2000 (gender, sexual orientation, family status, age, disability, race and membership of the Travelling community), two of the proposed additional grounds (criminal convictions and socio-economic status), and two other variables (homelessness, and literacy levels, which may have an influence on the effectiveness of prevention strategies). The choice of an equality framework is justified thus: 'The challenge for the Southern Regional Drugs Task Force in setting forth its four-year strategy is to ensure that the agreed policy and its implementation will meet people's needs and positively impact on their lives. To achieve that requires the rethinking of established norms. … More and more it has come to be accepted that the 'one size fits all' policy framework does not work and in its place what is required is a more targeted, focused approach.'[5]

While targeting is necessary to meet needs specific to particular groups experiencing inequality, Niall Crowley, CEO of the Equality Authority, has recently argued that that it must be matched by mainstreaming, which seeks to promote equality through all key policies, programmes and practices: 'A dual strategy means that some targeted initiatives will be taken to support the capacity of mainstream institutions and organisations to take account of diversity and to promote equality. It means that mainstreaming will stimulate decision makers to put in place targeted initiatives where inequalities are identified that will not be addressed by general policies, programmes or practices.'[6] *(Brigid Pike)*

1. Regional drugs task forces (RDTFs) were established in 2003, in line with Actions 92–97 of the National Drugs Strategy 2001–2008. Their terms of reference include the development of a 'co-ordinated and integrated response to tackling the drugs problem in their region'. To date, the strategic plans of five RDTFs have been described *Drugnet Ireland*: North East (Siobhán Reynolds, Issue 15, p.1), Western (Sarah Fanagan, Issue 18, p.19), Southern (Siobhán Reynolds, Issue 19, p.12), North West (Sarah Fanagan, Issue 19, p.21) and Midland (Sinéad Foran, Issue 20, p.13).

2. Western Drugs Task Force (2006) *Shared solutions: first strategic plan of the Western Regional Drugs Task Force*. Castlebar: WRDTF, p.37.

3. See Welshman J (2006) *Underclass: A history of the excluded 1880–2000*. London: Hambledom Continuum, for an account.

4. Neale J (2006) Social inclusion and drug policy. In Hughes R, Lart R and Higate P (eds) *Drugs: policy and politics*. Maidenhead, Berks: Open University Press, p.14.

5. Southern Regional Drugs Task Force (2005) *Strategic plan 2005–2008 and action plan 2005–2007*. Cork: SRDTF, pp.8–9.

6. Crowley N (2006) *An ambition for equality*. Dublin: Irish Academic Press, p.120.

Midland Regional Drugs Task Force: *Action Plan 2006–2008*

The Midland Regional Drugs Task Force (MRDTF), one of 10 regional drugs task forces (RDTFs), was established in 2003 with the assistance of the National Drugs Strategy Team (NDST). It covers counties Laois, Offaly, Longford and Westmeath. In November 2005 the MRDTF published its first action plan[1] to tackle drug misuse in the region.

The MRDTF action plan is the result of an extensive consultation process carried out in the region in 2005. This process allowed relevant statutory, voluntary and community groups to contribute to the development of the plan. Key issues relating to drug misuse in the region were identified, along with suggestions for addressing these issues; all contributions were taken into account by the MRDTF in the development of the action plan.

The plan sets out actions relating to the four pillars of the National Drugs Strategy. It includes a further strand concerned with structure, governance and ways of working. Alcohol use is not included in this plan except where it concerns under-18s, on the basis that alcohol is not an illicit drug. The following key actions are given high and urgent priority:

Education/Prevention

- Establish an inter-agency team in the MRDTF to develop and deliver accredited training programmes on substance misuse to local community development groups.
- Develop and disseminate a range of materials appropriate to relevant audiences, and train individuals to deliver these materials, with particular emphasis on out-of-school settings, non-formal education and parent-support settings.
- Design, develop and deliver a drugs education programme to GPs and pharmacies.
- Encourage and support the implementation of the Youth Work Act 2001 by assisting in the development of youth action plans and ensuring that substance misuse prevention is a key component of the plans.
- Ensure that all schools and other educational and training establishments implement a comprehensive substance misuse prevention programme and appoint a worker to support these programmes.

Treatment/Rehabilitation

- Provide and support a residential treatment/rehabilitation programme in the region.
- Provide a range of drop-in centres and facilities throughout the region for those affected by substance misuse. Initially this will involve four pilot projects, with a long- term goal to expand to twelve.
- Establish a support service for under-18s that is in line with the under-18s protocol.
- Ensure that drug users have access to detoxification programmes within the region.
- Establish a users group to provide feedback in relation to services in the region and to act as a support group for users.

Supply reduction

- Extend the community policing fora into the MRDTF area.
- Promote and support the establishment of estate-management programmes in high-priority estates in all four counties in the region.
- Explore the potential use of non-custodial interventions in tackling drug misuse.

Research

- Establish a programme for collecting local information that is up to date, using existing research mechanisms and a template designed for collecting data at a local level.
- Engage with young people in the region to ascertain their views.

Structure, governance and ways of working

- Select members of the MRDTF from among voluntary, community and public representatives, and senior decision makers in relevant agencies
- Appoint an MRDTF co-ordinator, a development worker and an administrator.
- Design and deliver an induction programme for new staff members and organise relevant training programmes for all members of the MRDTF.
- Initiate and support the establishment of community drug action groups in each major town of the region.
- Explore a co-ordinated approach between initiatives to deal with illicit drug use and alcohol abuse among teenagers and develop appropriate actions for reducing alcohol consumption.

(Sinéad Foran)

1. Midland Regional Drugs Task Force (2006) *Action Plan 2006–2008*. Tullamore: Midland Regional Drugs Task Force.

The Ready for Work programme

The RFW programme provides work experience opportunities to unemployed homeless adults.

On 24 November 2006 the Minister for Labour Affairs, Tony Killeen TD, launched the Business in the Community Ireland Ready for Work (RFW) programme review 2002–2006.[1] The overall aim of this programme is to enable homeless people to break the cycle of no home – no job – no home. The RFW programme provides work experience opportunities to unemployed homeless adults. It involves two days' pre-employment training, two weeks' unpaid work experience with in-house support, and follow-up support from training and employment officers and job coaches. Programmes are run three times a year and serve as a first step for candidates who have been through the homeless services, and in some cases the addiction and related support services, and are re-entering the world of work.

The review includes a number of candidates' stories highlighting the personal and social progress made in the course of their involvement with the RFW programme. Some describe the positive impact of treatment for alcohol and drug misuse in assisting the candidates to move beyond their experience of homelessness towards engagement with the programme.

The review also includes information on outcomes of the 12 programmes run in the years 2002 to 2006. It reports that 118 candidates commenced the programme, of whom 53 have commenced work; 44 have accessed further training and education; and 19 are now living independently.

The RFW programme is innovative in a number of ways.

Some 20 corporate supporters offer funding, facilitators, job coaches or work experience placements.

1. There is a strong partnership approach between the candidates, the business sector and homeless service providers such as the homeless agency. Some 20 corporate supporters offer funding, facilitators, job coaches or work experience placements. A minimum of 20 homeless service providers are engaged with and support RFW.
2. The programme has input from a steering group of members of the business community. The remit of the steering group is to increase awareness of the RFW programme among employers, to increase the pool of companies involved, to communicate issues faced by candidates to prospective RFW companies, and to ensure productive two-week placements by matching skills to jobs.
3. The programme offers job coaching by matching a volunteer from the business sector to a candidate who has completed a programme, in a six-month coaching relationship.

A study by Lawless[2] highlighted the lack of progression routes to work placement for participants in drug treatment and engaged in vocational training in Dublin North East. The National Economic and Social Forum[3] recently highlighted the issue of labour market vulnerability among marginalised groups and called for a targeted response to the issue. Platt[4] and Kemp *et al.*[5] highlighted the benefits of supported work interventions for groups such as clients in drug treatment and ex-prisoners with addiction issues. For example, knowing that work experience was a feasible option was a key motivating factor in completing training. Also, the high levels of support given to participants were a major factor in enabling the completion of programmes; this was a feature of the RFW programme.

The business sector also benefits from involvement in the RFW programme. According to the co-ordinator of the programme, Rosemary Carvill,

> the greatest learning for many of those in the corporate sector has been the realisation that people 'out of home and out of work' are not so different from themselves. They also discover how little it takes to help someone to regain control of their life.

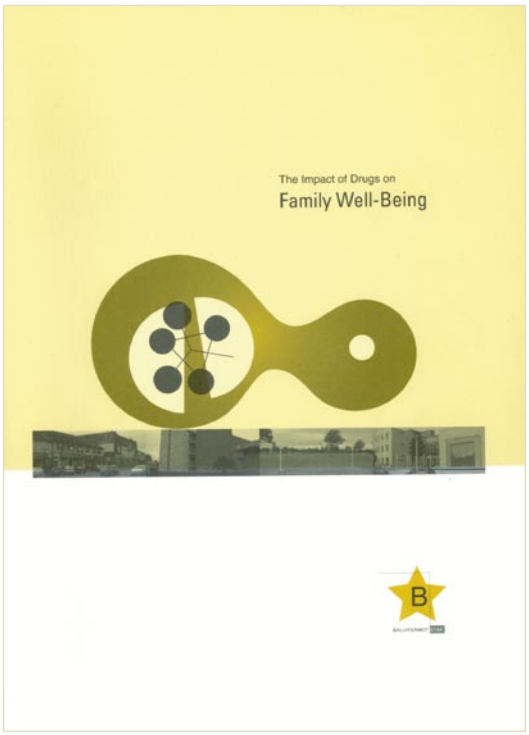
The RFW programme is an example that can be taken and developed by drug treatment agencies in partnership with employers in targeting the vocational and employment needs of individuals who are seeking to move beyond the drug treatment system. The merits of this programme have been extolled in a recent editorial in the *Irish Times* (30 October 2006):

> The Ready for Work scheme, designed to provide jobs for the homeless, is a particularly useful exercise in that it reaches out to the dispossessed and allows them a chance to start afresh. Homeless people are at a particular disadvantage when they look for work because they have to use a hostel or temporary accommodation as their address. As a result, they are invariably not called for interview. In order to circumvent that problem, a range of major companies have been encouraged to commit, in advance, to the employment of homeless persons.

(Martin Keane)

1. Business in the Community Ireland (2006) *Ready for Work review 2002–2006*. Dublin: Business in the Community Ireland.
2. Lawless K (2006) *Listening and learning: evaluation of Special Community Employment programmes in Dublin North East*. Dublin: Dublin North East Drugs Task Force.
3. National Economic and Social Forum (2006) *Creating a more inclusive labour market*. Report 33. Dublin: National Economic and Social Development Office.
4. Platt JJ (1995) Vocational rehabilitation of drug abusers. *Psychological Bulletin*, 117(3): 416–433.
5. Kemp K, Savitz B, Thompson W and Zanis DA (2004) Developing employment services for criminal justice clients enrolled in drug user treatment programmes. *Substance Use and Misuse*, 39(13,14): 2491–2511.

The impact of drugs on family well-being



A report commissioned by Ballyfermot STAR to assess the needs and well-being of service users attending the Ballyfermot-based initiative was launched on 15 September 2006.[1] The report is based on interviews carried out during 2004/05 with two groups of service users, one group of 45 attending the Family Support Programme (FSP) and a second group of 18 attending the Community Employment (CE) programme. The research used up to 17 standardised instruments to collect data on up to 14 different dimensions of well-being. This article will highlight under four headings some of the key findings from the report.

Characteristics of service users

Ninety-one per cent of FSP participants and 78% of CE participants were parents. Seventy-one per cent of FSP participants lived in a two-parent household; 57% of the CE group lived in a one-parent household. The report notes that the rate for lone parenthood in Ireland is 21%. CE participants were younger and tended to be living with all their children or with their parents, whereas FSP participants are more likely to be grandparents and to have acted in the role of full-time parents to their grandchildren. The report noted that nearly one-third of all service users lived in accommodation rented from the local authority – about four times the national rate.

Drug use in families of service users

Eighteen per cent of FSP participants and all the CE participants had used drugs. Both groups reported drug use by their partners, 13% of the FSP group and 22% of the CE group. Of the FSP participants, 76% reported a high level of drug use by their children, and 46% reported that a family member was a current active drug user.

A comparative assessment of the well-being of service users

When compared to a representative sample of parents in Ireland, Ballyfermot STAR service users had:

- much higher levels of negative emotions
- fewer positive emotions
- significantly lower levels of psychological well-being
- experienced higher numbers of negative life events in the past year
- significantly weaker support networks
- weaker parent-child relationships
- higher numbers and frequencies of physical symptoms.

On at least one significant dimension of well-being, participants on the CE programme fared badly compared to the FSP participants. For example, CE participants had dramatically reduced physical well-being; 90% were unable to work due to sickness or disability and 72% reported using prescribed benzodiazepines. The report noted that significant interventions would be required to bring levels of physical well-being among this group closer to the norm. These individuals had all been active users of illicit drugs and the majority were now stable on methadone and availing of the CE part-time work and vocational training programme to improve their employability.

However, research has cast doubt on the suitability of vocational training programmes for participants with questionable claims to stabilisation and poor health and physical well-being. For example, Kemp and Neale[2] pointed out that employability programmes can only realistically engage with clients who have achieved a consistent state of stabilisation and are in good health and secure accommodation.

Influence of drug use on family well-being

This part of the research focused exclusively on the 45 participants in the Family Support Programme (FSP). A key research question that runs throughout this report is: To what extent is the well-being of families negatively affected by drug use in the family? Nineteen per cent of families attending the Ballyfermot STAR centre had experienced the death of a family member as a result of drugs, and 59% of service users had a family member who had been imprisoned for using drugs. Furthermore, families with a member who used drugs, whether active (using illicit drugs) or stable (using prescribed drugs), had consistently lower levels of well-being than families that were drug free (without either an active or a stable drug user in the family).

On the other hand, FSP service users living in drug-free families had significantly higher levels of well-being than those living in families where drug use was either active or stable. In addition, service users living in drug-free families had significantly higher levels of well-being than the average Irish parent.

Nineteen per cent of families attending the Ballyfermot STAR centre had experienced the death of a family member as a result of drugs

Drugs and family well-being *(continued)*

However, the authors noted that, given that these data were cross-sectional (collected at one point in time) rather than longitudinal (collected at different points over time), it was not possible to be certain about the direction of the causation. Nonetheless, the report makes the case that it seems plausible to infer from the data that well-being is influenced by drug use, rather than the reverse, since those who were currently drug free had previously been active or stable. The authors concluded that, on balance, it was possible to infer from the data that the presence of a drug user in the family had a significant negative impact on the well-being of other family members.

This is an important piece of research into an area that is now being recognised at policy level and was highlighted in a study by Murphy-Lawless[3] on the impact of drug abuse on families in the north inner city of Dublin. The need to respond to the problems faced by families affected by drug misuse was recognised in the mid-term review of the National Drugs Strategy.[4] The review recommended that a new cross-pillar action be developed covering the broad area of family support, under which the recommendations of the recent family support study by the National Advisory Committee on Drugs[5] should be implemented.

It is important for communities that have been identified as areas with acute levels of problematic drug use and associated levels of socio-economic disadvantage, such as Ballyfermot, that policy responses remain targeted and sustained towards removing disadvantage and reducing the demand for illicit drugs. It is likely that such sustained and meaningful policy commitment will be met with an enhanced neighbourhood solidarity, as was reported by some of the participants in this study. As this research has also shown, users of the Ballyfermot STAR services reported huge satisfaction with their neighbourhood compared to the norm in Ireland. Moreover, participants on the CE programme, despite their own reported poor levels of physical well-being, were even more satisfied with their neighbourhood than the FSP participants. This was the only dimension of well-being in which service users displayed a level of well-being that was higher than the national norm. *(Martin Keane)*

1. McKeown, K and Fitzgerald G (2006) *The impact of drugs on family well-being*. Dublin: Ballyfermot STAR.
2. Kemp P and Neale J (2005) Employability and problem drug users. *Critical Social Policy*, 25(1): 28–46.
3. Murphy-Lawless J (2002) *Fighting back: women and the impact of drug abuse on families and communities*. Dublin: Liffey Press.
4. Steering Group for the mid-term review of the National Drugs Strategy (2001) *Mid-term review of the National Drugs Strategy 2001–2008*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
5. Watters N and Byrne D (2004) *The role of family support services in drug prevention*. Dublin: Stationery Office.

Rehabilitation Working Party: an update

On 9 November 2006, in response to a question in Dáil Éireann, Minister of State with responsibility for drugs strategy, Noel Ahern TD, stated: ' … a working group on drugs rehabilitation was set up in September 2005 under the aegis of my Department to develop proposals to augment existing rehabilitation services. The working group includes representatives from a range of Departments and agencies involved in delivering rehabilitation services, in addition to representatives from the national drugs strategy team, the National Advisory Committee on Drugs and the community and voluntary sectors. The terms of reference of the working group are broad and include examining the existing provision of rehabilitation services, identifying best practice, identifying gaps and recommending actions to develop an integrated rehabilitation service. Some of the group's key recommendations are likely to focus on ensuring that actions 47, 48 and 50 of the Strategy are met. These actions largely relate to providing a continuum of care for clients through planned progression paths for each problem drug user, while ensuring that quality standards are achieved in the services provided. The group is also likely to deal with wider supports which are needed by recovering problem drug users in areas like involvement in community employment schemes, educational supports and support with progression to employment, housing and child care. It will also recognise the need to involve the families of problem drug users in the process. I expect the working group to complete its report by the end of the year, with a view to beginning the implementation of its recommendations in 2007. I am aware that the HSE has established a working group on residential treatment and rehabilitation for substance users. This group, on which my Department is represented, is examining the residential rehabilitation requirements of people involved in all forms of substance misuse, including the misuse of alcohol. Its report is likely to be available early in the first half of next year.'

Blanchardstown Dial to Stop Drug Dealing campaign

It is difficult to establish the number of crimes that go unreported to the police. Surveys of crime victims have been used in other jurisdictions to estimate this 'dark figure' of crime.[1] For example, British Crime Surveys conducted at regular intervals since 1982 have led to estimates that only one in four of the crimes which occur appear in official records.[2] Other authors have suggested that, when petty offences such as shoplifting are included, the 'dark figure' can be as high as eleven times the police figure.[3] There is evidence to suggest that the 'dark figure' may be even higher in the case of drug offences and drug-related crime. A recent study conducted in Dublin's north inner city highlighted fear of reprisal from those involved in the drug trade as a significant disincentive to reporting such offences to the gardaí.[4]

In a unique approach to addressing such problems, the Blanchardstown Local Drugs Task Force (BLDTF) set up a non-Garda confidential phone line to help gather information on local drug dealing. The launch of the campaign in May and June 2006 involved, in the initial two weeks, the distribution of 30,000 brochures, 250 in-store posters and a local media event. Weeks three and four focused on older children and younger adults in formal and informal educational and community sectors, while peer-education teams spoke in schools and community centres. Week five involved a retail initiative including over twenty businesses – supermarkets and fast food outlets – which agreed to distribute campaign literature.

The confidential number was free so as to encourage its use by older children and young adults. The number was also anonymous so people could be reassured that they would not be required to be involved in possible ensuing legal proceedings. The use of a non-Garda number was regarded as important as it was felt that, for some local residents, phoning a police number would be a serious barrier. The service was open 24 hours, seven days per week. Also, it was not necessary to have witnessed drug dealing directly. Callers were encouraged to call with second-hand information. The phone lines were managed by a professional call centre.

The report of the evaluation of the project was launched by Noel Ahern TD, Minister of State with responsibility for drugs strategy in November 2006.[5] The report includes findings on the project from three sources: daily reports from the call center, a report from the Garda Síochána and a public survey of a sample of 250 people. Over the six-week period 296 calls were received. On foot of these, 100 detailed reports were sent to the gardaí. The Garda evaluation indicated that 67% of these reports provided 'somewhat useful or very useful' information. Cocaine was the subject of 42% of reports, followed by cannabis (27%) and heroin (17%). These were followed by ecstasy (7%), prescription drugs (5%) and steroids at 2%. Of the reports that were followed up by the drugs unit of Blanchardstown Garda Station, 17% were referred to other Garda districts, 17% resulted in arrests with court cases pending, 7% were awaiting further information, 2% were being monitored and 59% were part of ongoing investigations. The gardaí concluded that the project had helped raise awareness of the drug situation in the area and had helped identify drug dealers unknown to them.

The survey of public opinion provided information on local attitudes to the drug situation and the future potential for the development of the campaign. Included among the survey findings were the following:

- 89% of youths and 70% of adults regarded drugs as a 'very' or 'somewhat' serious problem.
- 46% of youths and 37% of adults responded 'yes definitely' when asked whether the public should be encouraged to help gardaí with the drugs problem in Dublin 15.
- More than half of the respondents spontaneously recalled the 'dial to stop drug dealing campaign'. The highest level of recall of campaign literature was for the brochures delivered door-to-door.
- That each call would be treated with absolute confidentiality was 'very important' for three quarters of the sample: 76% of youths and 73% of adults.
- The motivation to call either a Garda or non-Garda confidential telephone line was similar for both youths and adults and primarily driven by community spirit.
- The inhibitions about calling either confidential number related to a dislike or disregard for the gardaí, concern about anonymity and confidentiality, a reluctance to get involved and fear of reprisal.

Drug markets and drug-related crime at a micro-level can lead to the creation of 'no-go areas', the development of a culture of fear and the erosion of the social bonds which contribute to community cohesion. They can also intensify the stigmatisation often felt in communities where such problems take hold.[4] Initiatives such as

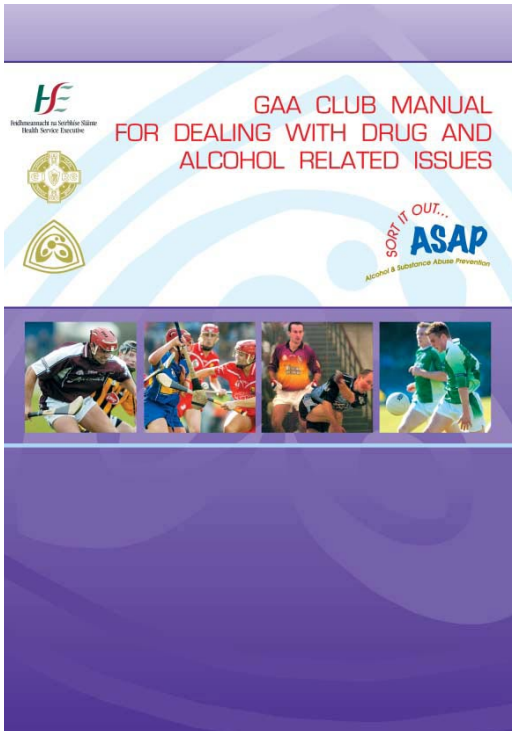
A recent study conducted in Dublin's north inner city highlighted fear of reprisal from those involved in the drug trade as a significant disincentive to reporting such offences to the gardaí.

Dial to Stop Drug Dealing *(continued)*

the Blanchardstown 'Dial to stop drug dealing' project, by seeking to develop a response which is sensitive to local conditions, represent an innovative approach in this area. Although the local campaign was due to end in December 2006, the steering group overseeing the project has recommended that it be adapted and rolled out on a national basis. *(Johnny Connolly)*

1. For a general discussion on the issues which arise in the context of crime statistics, see Maguire M (1997) Crime statistics, patterns, and trends: Changing perceptions and their implications, in Mike Maguire, Rod Morgan and Robert Reiner (eds) *The Oxford Handbook of Criminology*. For an Irish perspective on drug-related crime see Connolly J (2006) *Drugs and crime in Ireland*. Overview 3. Dublin: Health Research Board.
2. Hough J M and Mayhew P (1983) *The British Crime Survey*. Home Office Research Study No. 76. London: HMSO.
3. Sparks R, Genn H and Dodd D (1977) *Surveying victims*. Chichester: John Wiley.
4. Connolly J (2003) *Drugs, crime and community in Dublin: Monitoring quality of life in the north inner city*. Dublin: North Inner City Drugs Task Force.
5. Blanchardstown Local Drugs Task Force (2006) *Blanchardstown Dial to Stop Drug Dealing: campaign evaluation executive summary report*. Blanchardstown: BLDTF.

GAA publishes guide for clubs



Following on from the recommendations of the Gaelic Athletic Association (GAA) task force on drugs and alcohol (see *Drugnet Ireland* 18), the organisation recently published a guide for GAA clubs on developing policy in this area.[1] The task force recommended that each club develop a policy appropriate to their circumstances, and the new guide outlines a step-by-step approach to achieving this, emphasising the importance of involving members in this process. The guide contains specific recommendations, such as ending the traditional 'filling the cup' celebrations and phasing out alcohol advertisements on club jerseys and grounds. It also provides advice on using educational programmes to raise awareness of alcohol- and drug-related issues, and on responding to evidence of possible problematic behaviour among club members.

The GAA Alcohol and Substance Abuse Prevention (ASAP) programme emphasises the importance for clubs of developing links with professional drug and alcohol services in their local areas to assist them in the management of alcohol- and drug-related incidents and in the development of appropriate policies. To help with this, the guide contains a county-by-county listing of drug and alcohol services.

The ASAP programme is at an early stage. Eventually, each of the country's 2,500 GAA clubs will have an officer to co-ordinate and oversee the implementation of its own drug and alcohol policy. The new guide provides the template for this, but each club will decide what policies are appropriate to its particular circumstances and local conditions. *(Brian Galvin)*

1. Murphy B (2006) *GAA club manual for dealing with drug and alcohol related issues*. Dublin: Cumann Luthchleas Gael.

For further information, contact:

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Legal briefing 2006

This legal briefing reviews some of the significant drug-related legislative initiatives introduced during 2006.

On 1 January 2006 the **Railway Safety Commission** was established under the Railway Safety Act 2005.[1] The Commission regulates railway safety in Ireland and has wide-ranging powers to monitor and inspect railway infrastructure and to take enforcement action where necessary. Provisions in the Act relating to the testing of safety-critical workers for the presence of 'intoxicants', which include alcohol and drugs and any combination of drugs or of drugs and alcohol (Parts 9 and 10), give the Commission power to approve codes of conduct, sampling procedures and support services.

An **order under the Misuse of Drugs Act 1977** provides that, from 31 January 2006, 'any substance, product or preparation (whether natural or not), including a fungus of any kind or description, which contains psilocin or an ester of psilocin is a controlled drug for the purposes of the Act'.[2] The effect of this order is to render the possession or sale of so-called 'magic' mushrooms criminal offences under the Act. Heretofore, it was illegal to possess or supply magic mushrooms in a dried or prepared state but lawful to possess and sell them in their natural state.[3]

The **Criminal Justice Act 2006** was signed into law by the President on 16 July 2006. On 1 August 2006, Michael McDowell TD, Minister for Justice, Equality and Law Reform, signed an order bringing into operation a number of provisions contained in the Act that relate to the jurisdiction of district court judges to issue a search warrant when they are outside their own district.[4]

With regard to organised crime and drugs, the Criminal Justice Act 2006 provides a new definition of 'criminal organisation' as 'a structured group composed of three or more persons acting in concert, established over a period of time and having as its main purpose or main activity the commission of or facilitation of a serious offence'. The Act delineates new offences relating to participation in or assisting the activities of a criminal organisation.

The **Irish Human Rights Commission** (IHRC) has raised a number of concerns about some of the provisions of the Criminal Justice Act.[5] In relation to proposals contained in Part II, which add additional grounds to the mandatory sentencing guidelines for persons convicted in possession of drugs valued at €13,000 or more (Criminal Justice Act 1999), the IHRC states that it is concerned 'that the proposals in relation to the 10 year mandatory sentence may undermine the discretion of the judiciary to ensure that the sentence imposed is in line with the principle of proportionality, and to ensure that a fair balance is struck between the particular circumstances of the commission of the offence and the relevant circumstances of the person sentenced' (p.17). With regard to the determination of the market value of the drugs, the IHRC recommends that an objective expert witness be called to give an opinion on the valuation of drugs before the court. The IHRC is also of the view that the €13,000 valuation for drug trafficking offences should be reviewed in light of inflation and the current cost of drugs. The Act amends the law so that it will not be necessary for the prosecution to prove that a person charged with an offence relating to the possession of drugs under section 15A of the Misuse of Drugs Act 1977 knew that the value of the drugs in his or her possession was €13,000 or more, or was reckless in that regard. In relation to this provision, 'the IHRC is of the view that the removal of the element of knowledge or intention on the part of the accused person may raise questions around the forseeability of criminal liability. The IHRC recommends that the prosecution should be required to prove that the accused has reasonable grounds to believe that the drugs in his or her possession were worth €13,000 (or whatever the limit may be) or more' (p.17).

The IHRC has also raised concerns about the proposal in the Act to establish a Drug Offenders Register, modelled on the Sex Offenders Register provided for in the Sex Offenders Act 2001. It states that 'it is not apparent…how a drug offenders register will be an effective, necessary or proportionate response' (p.21) to the need to prevent drug trafficking, and it has requested further information from the minister on the purpose of the proposed register.

Implementation of laws

- It was reported on 5 May 2006 that plans are at an advanced stage for the extension of the Drug Treatment Court to include referrals from all courts in the Dublin metropolitan area.[6]
- Guidelines setting out the functions, composition and operation of joint policing committees (JPCs), established under the Garda Síochána Act 2005, were published in June.[7] JPCs are to be established in each of the 114 local authority administrative areas throughout the State. They will bring together representatives from the local authority, gardaí, public representatives and representatives of the community and voluntary sector to discuss and make recommendations on matters affecting the policing of the area.[8] *(Johnny Connolly)*

1. S.I. No. 841 of 2005. Railway Safety Act (Part 2) (Establishment Day) Order 2005.
2. S.I. No. 55 of 2006. Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2006.
3. Connolly J (2006) Government bans sales of 'magic' mushrooms. *Drugnet Ireland*, 17: 9.
4. The need for these provisions arose on foot of the Supreme Court judgement in the case of *Creaven & Ors v. Criminal Assets Bureau & Ors* [2004] IESC 92 (29 October 2004)
5. Irish Human Rights Commission (2006) *Observations on additional proposals for amendments to the Criminal Justice Bill 2004*. Dublin: IHRC.
6. O'Brien C (2006) Drug Treatment Court programme to be expanded. *Irish Times*, (5 May): 5.
7. Department of Justice Equality and Law Reform (2006) *Garda Síochána Act 2005: Joint policing committee guidelines*. Dublin: Department of Justice Equality and Law Reform.
8. Connolly J (2006) Guidelines on joint policing committees. *Drugnet Ireland*, 19: 9.

New Eurobarometer survey on AIDS prevention

In October 2006, the European Commission published a Special Eurobarometer survey on AIDS prevention.[1] This survey gathered public opinion from 25,000 respondents in the 25 member states, the four acceding and candidate countries, and the non-government-controlled areas of Cyprus. In Ireland, TNS MRBI carried out 1,000 interviews between September and October 2005. Results of this survey are compared with a Eurobarometer survey on this issue which took place in the 15 member states in 2002.[2]

Respondents' perceptions about how people catch HIV and AIDS

According to the survey report, 'Europeans know how HIV can be contracted but some uncertainty emerges when it comes to ways in which the virus cannot be transmitted.'

Almost all respondents (97%) knew that it is possible to contract HIV by an infected needle, by receiving infected blood, and by having sex without protection with someone who has AIDS or who is HIV positive.

When asked about ways in which HIV or AIDS cannot be transmitted, respondents were more uncertain. Only 40% knew that it is not possible to be infected with HIV by kissing on the mouth. Almost half (around 45%) mistakenly believed that it is possible to be infected by sharing drinking glasses or toilet seats with, donating blood to, or taking care of HIV-positive or AIDS patients. There were some large differences between the highest and the lowest percentages of correct answers given. For instance, 89% of Swedes knew that it is not possible to become HIV positive by giving blood, compared to 16% of Slovakians.

Most Europeans knew that it is not possible to contract AIDS or HIV by shaking hands with, handling objects touched by, or eating a meal prepared by someone who has AIDS or is HIV positive. Respondents from new member states were more likely than those of the old EU15 to give an incorrect answer to questions relating to ways of contracting the disease.

Irish responses tended to fall below the European average for correct answers (Table 1). There was a greater level of uncertainty about the way HIV and AIDS can be contracted, with more 'possibly' and 'don't know' answers throughout.

Table 1 Respondents' knowledge about the ways AIDS can be caught

		No %	Possibly %	Yes %	Don't know %
Being injected with a needle which has been used by someone who has AIDS or who is HIV positive	EU*	1	3	94	1
	Ireland	1	6	90	4
Receiving blood from someone who has AIDS or who is HIV positive	EU	1	3	94	2
	Ireland	1	5	91	3
Having sex without protection with someone who has AIDS or who is HIV positive	EU	1	3	94	2
	Ireland	1	6	90	4
Kissing on the mouth someone who has AIDS or who is HIV positive	EU	40	30	24	6
	Ireland	28	38	23	11
Drinking from a glass which has just been used by someone who has AIDS or who is HIV positive	EU	52	27	15	6
	Ireland	48	28	11	13
Giving blood	EU	54	13	30	3
	Ireland	59	14	17	10
Sitting on a toilet seat which has been used by someone who has AIDS or who is HIV positive	EU	55	26	13	7
	Ireland	51	25	11	13
Taking care of someone who has AIDS or who is HIV positive	EU	58	25	12	4
	Ireland	58	22	10	10
Eating a meal prepared by someone who has AIDS or who is HIV positive	EU	70	17	7	6
	Ireland	71	13	4	12
Handling objects touched by someone who has AIDS or who is HIV positive	EU	78	13	5	4
	Ireland	75	11	4	10
Shaking hands with someone who has AIDS or who is HIV positive	EU	83	9	5	3
	Ireland	77	12	4	7

*EU figure is the aggregate percentage from 25 member states

New Eurobarometer survey *(continued)*

Since 2002, awareness had dropped in Italy, Spain and the UK, but levels were notably higher in Portugal and Germany and, to some extent, in France and Belgium. Irish awareness does not appear to have changed significantly over this time.

Changes in respondents' behaviour since the emergence or spread of AIDS

Almost half (48%) of respondents said that the emergence of AIDS had led them to take precautions in sexual intercourse, and 38% now sought more stability in their choice of partners. It had led a small minority of respondents to try to 'avoid certain company' (17%), to take more care over the things they touched (14%), and to avoid 'certain places' (14%). Fewer people in 2005 than in 2002 reported taking these precautions (Figure 1).

Perceived effectiveness of measures undertaken in the respondents' countries

Overall, most Europeans saw measures undertaken in their country to stop the spread of AIDS as 'very effective' or 'fairly effective'. Almost 70% believed that treating and looking after someone with AIDS was the most effective measure used. The Irish were less positive about the effectiveness of measures undertaken in Ireland, with a drop in perceived effectiveness since 2002 (Figure 2).

Respondents' attitudes to harmonisation of efforts within the European Union

With the exception of the UK, Denmark and Spain, the majority or respondents (average 87%) in all countries were in favour of greater collaboration and harmonisation of efforts within the EU in terms of funding research to find an AIDS vaccine and in the treatment and care for those who have HIV or AIDS. They also thought that the EU should launch information campaigns on risky behaviour.
(Mary Dunne)

1. http://ec.europa.eu/public_opinion/archives/ebs/ebs_240_en.pdf
2. The 2002 survey was conducted under the framework of the Eurobarometer (special Eurobarometer 183–2 / Wave 58.2). It is available (only in French) at http://ec.europa.eu/public_opinion/archives/ebs/ebs_183.2_fr.pdf

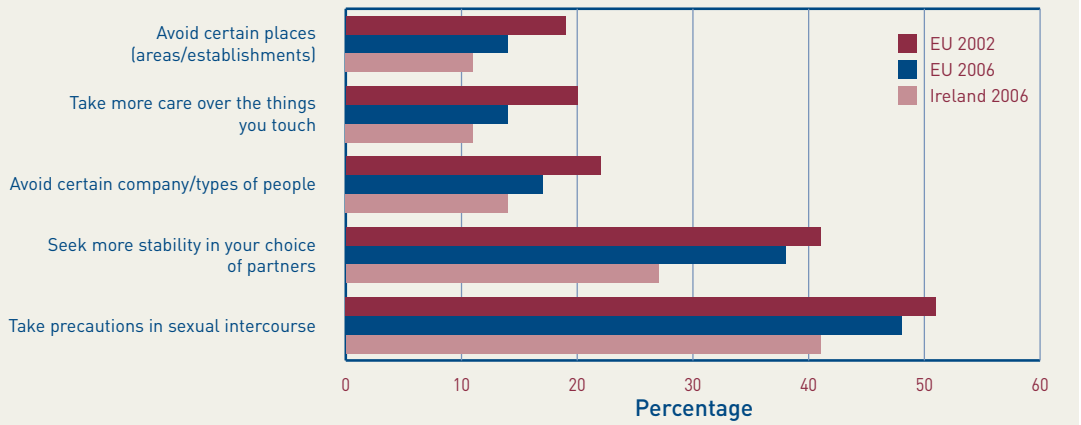


Figure 1 Changes in respondents' behaviour since the emergence and spread of AIDS

Source: *AIDS Prevention* Eurobarometer 2006

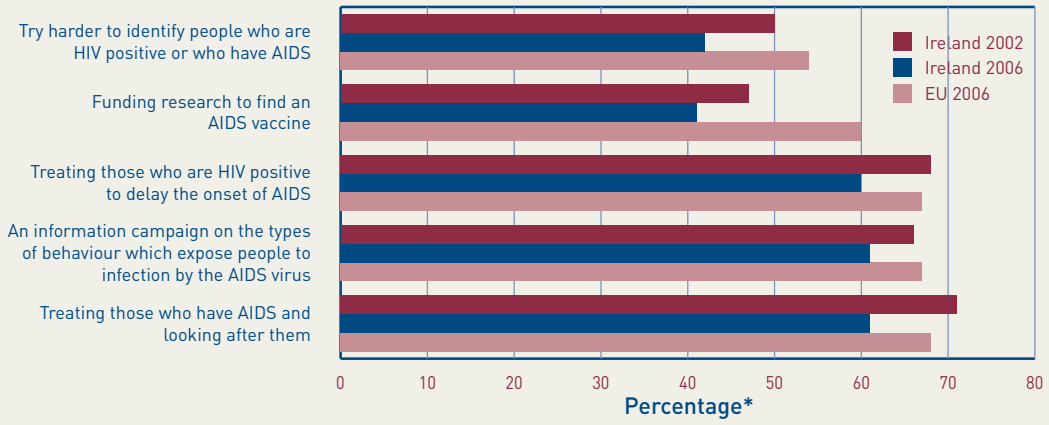
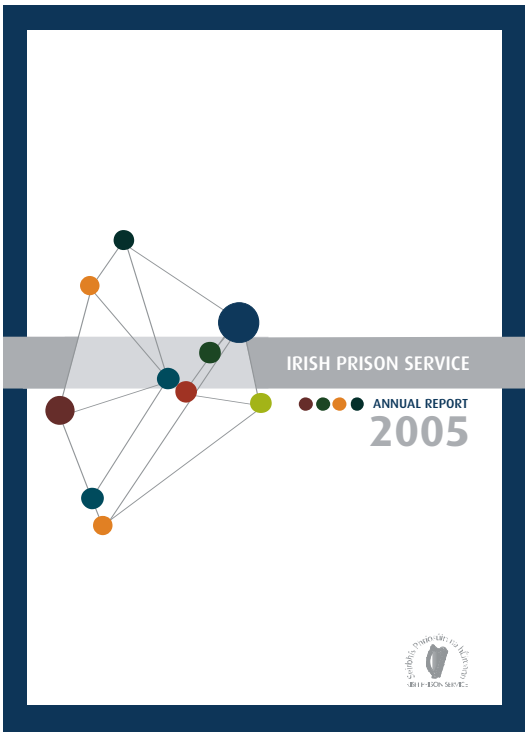


Figure 2 Perceived effectiveness of measures undertaken in respondents' countries
*Sum of percentages of 'very effective' and 'fairly effective' answers

Source: *AIDS Prevention* Eurobarometer 2006

Irish Prison Service – *Annual Report 2005*



The Irish Prison Service (IPS) annual report for 2005 was published in September 2006.[1] The aim of the IPS healthcare system is to deliver a standard of healthcare to all prisoners that is equivalent to that available in the wider community. Healthcare is provided to prisoners at the level of primary care, by general practitioners, nurses and medical orderlies.

The aim of the IPS healthcare system is to deliver a standard of healthcare to all prisoners that is equivalent to that available in the wider community.

The mid-term review of the National Drugs Strategy in 2005 recommended that the IPS collaborate with key stakeholders such as the Drugs Strategy Unit of the Department of Community, Rural and Gaeltacht Affairs and the National Drugs Strategy Team (NDST). Acting on this recommendation, the IPS presented relevant issues on the drugs situation in prisons to the NDST and the National Advisory Committee on Drugs. The NDST now wishes to incorporate individual prisons into the work of the local and regional drugs task forces.

Drug treatment

A total of nine prisons provide methadone treatment, with 1,564 prisoners receiving methadone substitution in 2005, an increase of 255 (16.5%) on the previous year (Table 1). Of these, 169 individuals received methadone substitution for the first time in prison.

In October 2005 the HSE and the IPS awarded a joint contract to a pharmaceutical company for the supply of methadone. This joint purchasing agreement will ensure:

- continuity of treatment for prisoners who move between the community and prison
- a regular supply of methadone
- significant cost savings to the IPS.

In 2005, a contract was awarded for the provision of pharmacy services to Shelton Abbey. Due to the lack of professional pharmacy services in prisons, the IPS now intends to introduce a contracted pharmacy service provided by a community pharmacy to all prisons. Such a service will result in improved patient care and efficient use of medicines.

Other significant developments in the prison healthcare system in 2005 were:

- A clinical data system which will record and store clinical information across the prison system was developed.
- An overall Strategic Statement which will inform the medium-term development and provision of prison healthcare was finalised.
- A joint initiative between the IPS and the HSE South Western Area led to the appointment of a consultant psychiatrist in adult addictions. This contributes to the healthcare strategy and increases the range of in-reach services available to prisoners. A similar appointment was made in the HSE Northern Area in 2004 to provide sessions at the Mountjoy complex.
- The role of healthcare managers in the IPS was highlighted in the Proposal for Organisational Change (which dealt with revised working arrangements in prisons), and a clinical nursing management structure within the prison system is being introduced.

(Siobhán Reynolds)

1. Irish Prison Service (2006) *Annual Report 2005*. Dublin: Irish Prison Service.

Table 1 Numbers receiving methadone substitution treatment in Irish prisons in 2005

Prisons	Total patients	New patients
Cloverhill Prison	571	97
Dochas Centre	228	27
Limerick Prison	4	0
Midlands Prison	6	0
Mountjoy Main Prison	511	27
Mountjoy Prison Medical Unit	79	5
Portlaoise Prison	2	0
St Patrick's Institution	1	0
Wheatfield Prison	162	13
Total	**1564**	**169**

Merchants Quay Ireland – *Annual Review 2005*

Merchants Quay Ireland (MQI) launched its annual review for 2005[1] on 29 September 2006. Speaking at the launch, chief executive Tony Geoghegan said that the number of people using MQI's drugs and homeless services had grown last year.

The city-centre needle exchange and the health promotion programmes were particularly busy. He said that more than 3,000 people had used the agency's needle-exchange service last year. The report shows that a total of 470 new injectors presented in 2005, up 6% on 2004. Mr Geoghegan said that people tended to inject drugs for a year before they sought treatment, and that during this period they were putting themselves at risk of contracting hepatitis C or HIV. He expressed concern at the high number of people accessing the MQI service and highlighted the lack of localised harm-reduction services.

The report also highlights the increasing demand for MQI's homeless services, particularly by people from the new EU member states. By September 2005 there was an average of 20 to 30 eastern Europeans attending the service every day. In response to this, MQI has produced information leaflets in a number of languages and some staff have taken language classes.

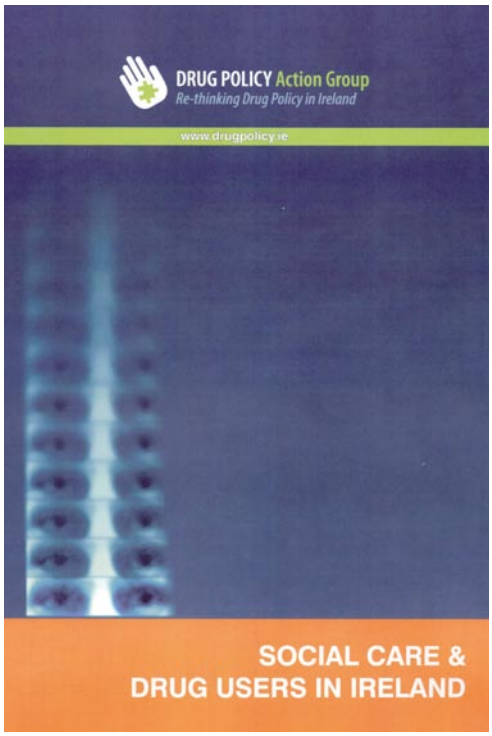
The types of service offered by MQI and the numbers of people accessing them in 2005 are shown below. *(Siobhán Reynolds)*

1. Merchants Quay Ireland (2006) *Annual Review 2005*. Dublin: MQI.

Broadcaster George Hook, who launched the MQI annual review (Photo: Laurence Boland)

Service	Type of intervention	Number of participants	Outcomes
Needle exchange health promotion services	Promoting safer injecting techniques HIV and hepatitis prevention Safe sex advice Information on overdose	3,339 (including 470 new injectors) 321 safer injecting workshops	Not available
Stabilisation services	Methadone substitution	29	Not available
	Supportive day programmes	11	Not available
	Gateway Programme	33 (average per month)	Not available
	Counselling	Not available	Not available
Settlement service	Assist service users to access interim and long-term accommodation	An average of 80 service users a month	An average of 10 service users availed of the Tenancy Sustainment Service each month
Integration programmes	Access to transitional accommodation (Ballymount House) for up to 24 weeks Group and one-to-one therapeutic sessions	12	Not available
Training and work programmes	FÁS Community Employment scheme	140	70 secured permanent employment or moved to further education
	Catering training programme	22	20 registered for certification for FETAC National Certificate in culinary skills
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	51 (of whom 13 were admitted for detoxification)	11 completed detox
St Francis Farm	Therapeutic facility offering a 6–12-month programme	26	12 completed 3 months or more

Drug Policy Action Group recommends co-ordinated social care for drug users



the authors highlight two vital components of social care, employment and housing

In November 2006 the Drug Policy Action Group (DPAG)[1] launched two policy papers in Dublin. Policy Paper 1 deals with criminal justice drugs policy in Ireland and Policy Paper 2 raises a number of questions around the social care of drug users in Ireland. This article will focus on the latter paper, written by Gemma Cox and Fr Peter McVerry – *Social care and drug users in Ireland.*[2]

The authors acknowledge that, for a large majority of people, social care is provided by family, friends and neighbours through informal networks of mutual support and is supplemented by state-sponsored institutional care through the public health system, social care services and education, employment and housing supports. But, the paper points out, very often the most vulnerable members of society, including a high proportion of drug users, who have the most complex needs, are likely to fall between the gaps in services. When drug users present for help and support, very often to specialist drug treatment agencies, a high proportion present with multiple problems, including psychological and serious mental health problems, employment and economic issues, poor living arrangements, familial and social relationship difficulties, and legal problems.

The paper claims that the way the specialist drug treatment service has evolved in Ireland (in a similar way to that of other health and social care services) means that it operates largely in isolation from other services and is generally unable to deliver a continuum of care. While the drug treatment service may be doing an excellent job in responding to people's addiction problems, there is a lack of co-ordination between drug services and agencies and other generic social care services, such as housing agencies, national training and employment agencies and mental health services.

In particular, the authors highlight two vital components of social care, employment and housing, and argue that, because of the uncoordinated nature of social care services targeting drug users, these needs are not addressed in a meaningful manner. For example, the report highlights the strong association between unemployment and problem drug use, but rightly notes that the causal direction of the association is complex. Nonetheless, it notes that improving employability for problem drug users can be a major factor in preventing relapse. Platt's review of treatment outcomes in the US[3] also finds an association between improved employability and reduced relapse. For example:

- Persons in treatment who are employed stay in treatment longer and achieve better outcomes than their unemployed counterparts.
- Persons who are regularly employed have lower rates of substance misuse than those who are sporadically employed or unemployed.

The authors argue that work provides a sense of responsibility, personal value, independence, security, dignity and a stake in society. This is a view shared by problematic drug users interviewed by Neale (2002)[4] in Scotland, who recognised the benefits accruing from employment, such as self-esteem, pride and a means of avoiding stigma. According to Neale, a job was seen by those interviewed as central to the process of recovery, since working

Drug Policy Action Group *(continued)*

provided a distraction and an alternative structure to their days.

On the other hand, the authors note that enhancing the employability of drug users has not traditionally been a priority for treatment and rehabilitation services, where the clinical goals of abstinence or stability and maintenance are generally given priority. This is a view partially articulated in a recent report by the National Economic and Social Forum.[5] The report identifies people with drug and alcohol dependencies as one of the marginalised groups particularly prone to experiencing labour market vulnerability, and states that there is a lack of employment support mechanisms to assist their progression.

The DPAG recognises that housing is more than simply providing a roof over someone's head. It is also about providing security, privacy and a space to develop. Housing is a vital component of social care and often the key to independent living. For many problem drug users, family and friends provide the main form of social care in terms of housing; however, living in the family home does not always work out. Research by Houghton and Hickey (2000)[6] and O'Brien *et al.* (2000)[7] highlights the association between problem drug use and family conflict and relationship breakdown in the home, often leading to those with addiction problems experiencing homelessness.

The paper concludes with five recommendations; the DPAG believes that, where a commitment is given to these recommendations, benefits will occur at policy, organisational and service-user level. The recommendations are reproduced below.

1. The DPAG recommends an understanding of 'complex needs' which takes into account that each separate need interlocks with all of an individual's other needs and cannot be adequately addressed in isolation from those other needs

2. The DPAG recommends that social care providers prioritise the importance of, and agree upon a strategy to develop, a strong organizational commitment to interagency work, which collectively will enhance the provision of social care services in Ireland.

3. The DPAG recommends the development of an interagency strategy to provide accessible entry to and retention within and across social care services in Ireland.

4. The DPAG recognises the importance of service user involvement in the development and implementation of existing and emerging models of social care delivery for problem drug users.

5. The DPAG believes that a published national audit of social care services/agencies is a necessary first step towards highlighting the current state of affairs, progress made and necessary improvements.

The presentation of this paper in a public forum provided an opportunity to discuss and debate the merits or otherwise of the central claims contained therein. The paper challenges both policy makers and service providers to consider ways of addressing the complex needs of drug users within a multidisciplinary social care model. Two elements of a social care approach are user involvement and inter-agency working. Such an approach integrates drug treatment services with employment and housing services. *(Martin Keane)*

The report identifies people with drug and alcohol dependencies as one of the marginalised groups particularly prone to experiencing labour market vulnerability

1. For more on the DPAG, see www.drugpolicy.ie

2. Cox G and McVerry P (2006) *Social care and drug users in Ireland*. Policy Paper 2. Dublin: Drug Policy Action Group.

3. Platt JJ (1995) Vocational rehabilitation of drug abusers. *Psychological Bulletin*, 117(3): 416–433.

4. Neale J (2002) *Drug users in society*. Basingstoke: Palgrave Macmillan.

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The National Documentation Centre on Drug Use

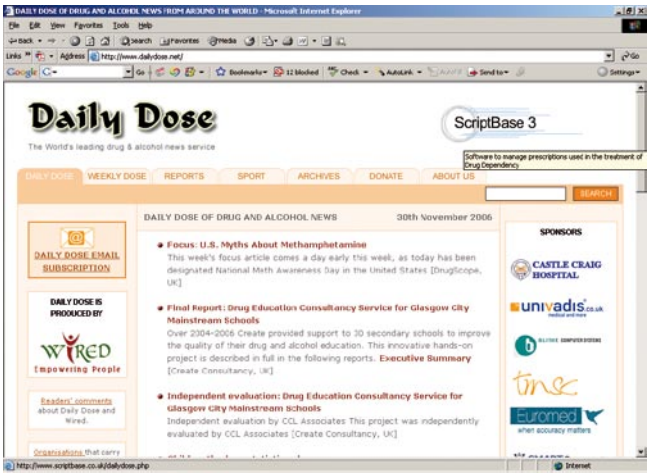
Keep up to date with online information in the drugs field.

There is a great variety of freely available online content providing very useful information in the substance use and addiction fields. In this issue of *Drugnet Ireland* we present a sample of websites in the UK which may complement the information sources you currently use.

Daly Dose www.dailydose.net

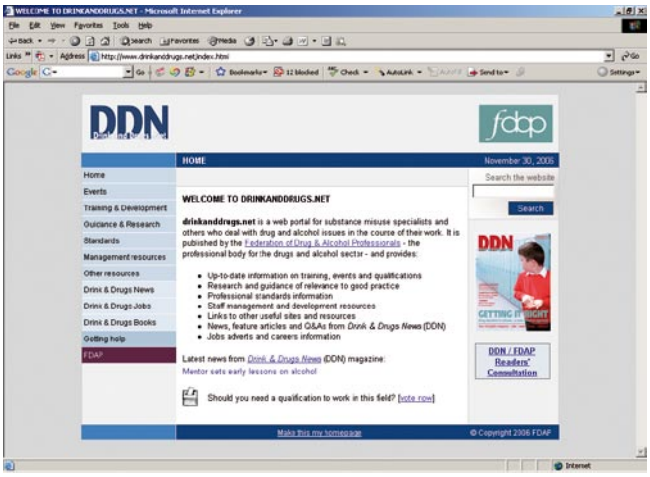
Daily Dose was launched in January 2001 and claims to be the world's leading news service on drug and alcohol misuse. The website is updated daily and provides links to a range of relevant material from specialist organisations and the popular media from around the world. Daily Dose is maintained by Wired, a voluntary organisation comprising people working in the drugs field. According to their website (www.wiredinitiative.com/index.htm) 'Wired is a grass roots initiative that merges real world activities with an exceptionally high profile web based communication system, for the purpose of disseminating information, providing support, education and training, conducting research, and amplifying the capacity of already successful programmes to reach their audiences.'

Daily Dose also includes a Weekly Dose with links to the highlights of the week, an archive of published items and an archive of links to specialist reports and papers.



Drink and Drugs News www.drinkanddrugs.net/

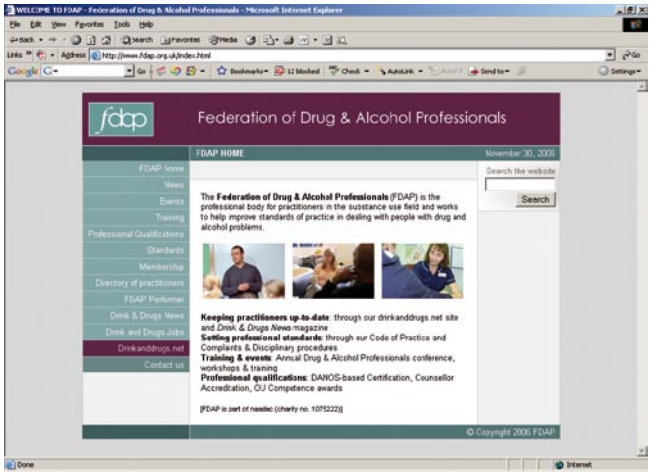
Drink and Drugs News is a fortnightly free magazine for those working in the drugs field and in the wider health, social care and criminal justice fields who deal with drug and alcohol issues in the course of their work. It is published by the Federation of Drug and Alcohol Professionals, Wired and CJ Wellings, a publishing company. It provides news from the field, feature articles, professional advice, policy analysis and other useful material.



National Documentation Centre *(continued)*

Federation of Drug and Alcohol Professionals www.fdap.org.uk

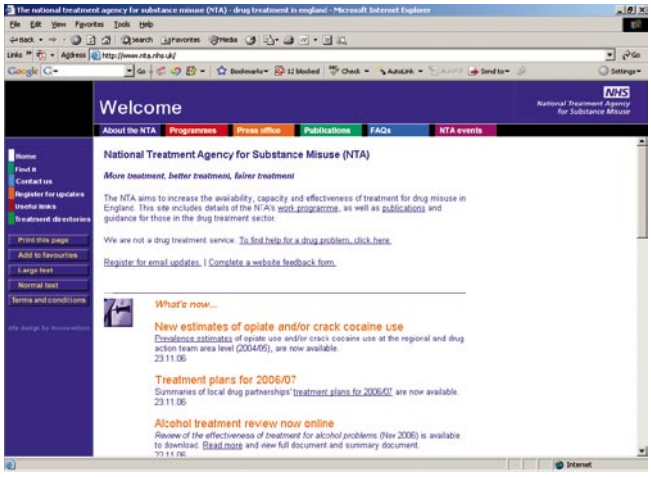
The Federation of Drug & Alcohol Professionals (FDAP) is the professional body for practitioners in the substance use field in the UK. The FDAP works to help improve standards of practice in dealing with people with drug and alcohol problems. The website contains up-to-date information on training, professional qualifications and standards in the field.



National Treatment Agency www.nta.nhs.uk/

The National Treatment Agency (NTA) is a special health authority created by the British Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in the UK. Its goal is to ensure that more treatment, better treatment and fairer treatment is available to all those who need it.

The site contains a great deal of valuable information on treatment services in the UK as well as publications and information on policy developments. *(Brian Galvin)*



NDC electronic Newsletter

Do you want to stay up to date on current news relating to drug use in Ireland?

The NDC e-newsletter provides news and information on new publications and selected parliamentary debates relating to the drugs issue on a monthly basis to all subscribers. The newsletter is emailed directly to your desktop and has substantial links to full-text publications and other news sources. Please email Louise Farragher louise@hrb.ie if you wish to subscribe to the e-newsletter.

National Documentation Centre *(continued)*

Recent visitors to the NDC

Students from the UCD Diploma in community drugs work (An Cosán/The Shanty Education and Training Centre)

Students from the UCD Diploma in community drugs work (Urrús/Ballymun Youth Action Project)

Students from the TCD Diploma in addiction studies

In brief

On 24 August 2006 the **Fourth Annual Report of the Inspector of Prisons and Places of Detention for the Year 2004–2005** was published. It states that, 'One of the greatest problems in prisons is the drug culture' and 'there should be no drugs in prisons'. To this end, it recommends that 'sniffer dogs be used to deal with all persons (not merely visitors) entering the prison'. www.justice.ie

On 1 September 2006 the **Report of the Commission of Investigation (Dean Lyons Case)** was released. It concludes that there was no deliberate attempt to undermine the rights of Dean Lyons. Instead, the report concludes that 'inappropriate leading questions were inadvertently asked by interviewing Gardaí'. A copy of the report has been sent to the expert group set up in light of concerns arising from the case. It will report to the Minister for Justice, Equality and Law Reform on the adequacy of Garda training, protocols, regulations and procedures in assessing the fitness of persons to be interviewed. www.justice.ie

In September 2006 the **UN Committee on the Rights of the Child (CRC)** considered Ireland's second periodic report, submitted under Article 44 of the Convention on the Rights of the Child (CRC/C/IRL/CO/2). Among its Concluding Observations, the Committee recommends that Ireland strengthen its efforts to address alcohol consumption by children. It also expresses concern about the apparent link between underage substance abuse and the suicide rate. www.ohchr.org/english/bodies/crc/

In September 2006 the **National Office for Suicide Prevention (NOSP)** published its first annual report, for 2005. In relation to alcohol and substance abuse, the report states that, 'Issues around the risk of alcohol and substance abuse are routinely incorporated into awareness training delivered by the HSE Resource Officers for Suicide Prevention.' www.nosp.ie

On 1 October 2006, **World Hepatitis Awareness Day**, the Central and Eastern European Harm Reduction Network (CEEHRN) released a fact sheet entitled *Hepatitis C among drug users in the new EU member states and neighbourhood*. The eight-page document contains recommendations for action by different groups, including policy-makers, intergovernmental and international agencies, health care authorities, low-threshold and other health service providers, pre-trial detention and imprisonment institutions, and researchers. www.ceehrn.org/hepatitis

On 5–7 October 2006 the **9th Annual European Conference on Drugs and Infection Prevention in Prisons** was held in Ljubljana, Slovenia. Organised by the European Network on Drugs and Infection Prevention in Prison (ENDIPP), this conference focused on 'bridging the gap' – analysing the barriers to providing an equivalence of care inside prisons to that which is available outside. www.endipp.net

On 9 October 2006 **A Cross-Border Organised Crime Assessment 2006** was released. Based on intelligence and information provided by state agencies on both sides of the border (including police, customs, asset recovery), the report looks at criminal gangs on both sides of the border, the impact of the border on criminal activity, and the costs of organised crime. It states that the border has little or no effect on the distribution of illicit drugs. While there are differences in the extent of the drugs markets north and south of the border, there remain strong cross-border links with networks of traffickers from both sides of the border working in co-operation to import and distribute drugs. www.justice.ie

On 24 October 2006 the **European Commission** adopted a Communication setting out an EU strategy to support member states in reducing alcohol-related harm (COM/2006/0625 final). The priorities identified in the Communication are to: protect young people and children; reduce injuries and deaths from alcohol-related road accidents; prevent harm among adults and reduce the negative impact on the economy; raise awareness of the impact on health of harmful alcohol consumption; and help gather reliable statistics. www.europa.eu/health/

On 26–28 October 2006 **Correlation, the European Network for Social Inclusion and Health**, hosted a seminar in Dublin Castle on ***Impacting policy – making voices heard***. Working in subgroups and providing skill-building through workshops, the seminar attempted to facilitate exchange of expertise from service users and professionals to policy makers and vice versa. A limited number of 50-70 participants were carefully selected so as to give representatives from all 25 EU member states and all professional backgrounds the chance to join in. Best practice examples were selected from integrative work for the marginalised in three fields, including work in relation to drug users. www.correlation-net.org

On 27 October 2006 the **Central Statistics Office (CSO)** published the reported crime statistics, including drug-related crime, for the 3rd quarter of 2006.This publication marked the formal transfer of responsibility for the published results from An Garda Síochána to the CSO. The CSO has established an Advisory Group to review the current methodologies for the analysis and presentation of the data, with a view to being able to 'better align crime statistics with public and specialist user needs'. www.cso.ie

On 5 December 2006 **Suboxone (buprenorphine and naloxone combined)** was the subject of a parliamentary reply by Minister for Health and Children, Mary Harney TD. She stated: 'Suboxone has recently been granted an EU license [sic] via central procedure by the EMEA, and preliminary studies have shown that the combination drug is as effective as Subutex (buprenorphine alone) in the management of opioid dependence and that it has less abuse potential. My Department is considering the implications of the introduction of the combination drug Suboxone and its use as a possible treatment for opiate dependency. In that context, my officials will be meeting the license holders, Schering-Plough in the coming week to discuss the best approach on its probable Irish launch in early 2007.' www.oireachtas.ie

(Compiled by Brigid Pike)

Recent publications

Books

Drugs: policy and politics

Hughes R, Lart R and Higate P (eds)
Open University Press 2006, 140 pp.
ISBN-13: 978 0 335 21616 1 (paperback)

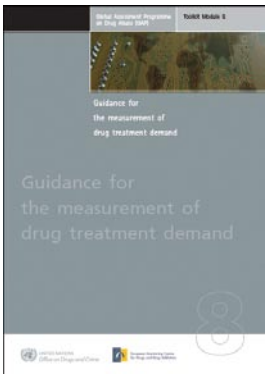
This 140-page book provides a set of tools with which to think about the complexity of drug use, through discussions of broader social policy and of the criminal justice and health policy fields. It concentrates on policy as developed in the UK and Europe. A theme common to all contributors is the need for policy responses to reflect the social diversity of drug users.

In Chapter 1 Joanne Neale considers the concept of social exclusion. She argues that 'where social exclusion and drugs appear together, only problematic drug use is … considered'. She goes on to argue that placing the problem drug user within the social exclusion framework masks the fluidity and dynamism of individuals' everyday experience and reduces the scope for effective policy responses. The authors of chapters 2–4 examine the discourses surrounding three specific population groups and their drug use – Trish Harding on women, Margaret Melrose on youth, and Kazim Khan on those defined by their racial or ethnic identity – and all emphasise the need to consider drug-using members of these groups in their wider social context.

In chapters 5 and 6 the authors problematise the relations between drugs and the law, and between drugs and the criminal justice system. In tackling the moral debate concerning the legal control of drugs, Mike Shiner argues for a reconfiguration of drug-related harm and the law through development of a restorative justice system that combines care and control. Rhidian Hughes and Nerys Anthony stress the difficulties of understanding drugs and crime as causally linked, again arguing that drug users need to be located in their broader social contexts and that the diversity of drugs users and drug use needs to be taken into account.

In Chapter 7 Rachel Lart explores the way drugs policy can be seen to mirror broader concerns and directions in health policy. Central themes include the relationship between the medical profession and the state, the development of coordinating structures across sectors and between levels of government, and the growing importance of evidence-based knowledge as a basis for policy.

In chapter 8 Henri Bergeron and Paul Griffiths make three key points about EU drug policy: until recently the idea of a common European drug policy was more rhetoric than reality; European drug policy was characterised by diversity rather than homogeneity; and that a 'drift to convergence' might be happening as a consequence partly of concern about the spread of HIV and partly a concern about public security, criminal activities and drugs.

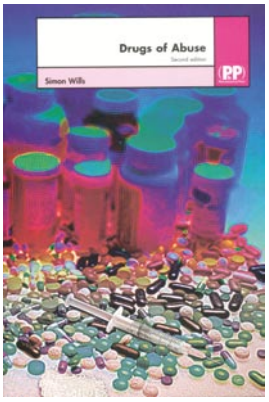


Guidance for the measurement of drug treatment demand

Toolkit Module 8
Global Assessment Programme on Drug Abuse in collaboration with the European Monitoring Centre for Drugs and Drug Addiction
United Nations, 2006

Toolkit Module 8 is designed to improve common standards for collecting and monitoring data on drug treatment demand. It is intended to help UN member states to develop drug information systems that are culturally appropriate and relevant, to ensure that existing systems conform to internationally recognised standards of good practice and to focus on the harmonisation of drug abuse indicators. It incorporates experiences of major ongoing treatment information systems and provides concrete guidelines for establishing and managing systems to facilitate comparative data analysis.

The module describes a dual approach to developing a drug information system, one that incorporates an operational perspective (the ground-level, practical or 'bottom-up' approach) and an organisational perspective (the political or 'top-down' approach). Chapter II sets out the benefits of collecting drug treatment data and describes some of the limitations that may apply. The remaining five chapters outline the logical stages in the development of a successful system under the following headings: Building your foundation; Data issues; Implementation; Analysis and reporting; and Maintenance and evaluation.



Drugs of abuse (2nd edition)

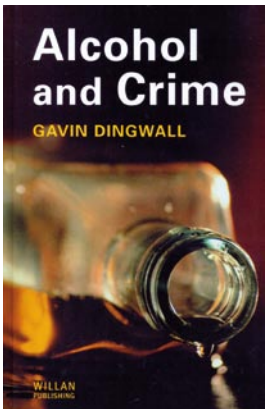
Wills S
Pharmaceutical Press
2005, 399 pp.
ISBN 0 85369 582 2 (paperback)

The author attempts to put the importance of drug abuse as a world health problem into perspective in the opening chapter

Recent publications *(continued)*

of this book. He points out that the number of people who die because of the effects of tobacco and alcohol – which are legal substances in most countries – far exceeds the number killed by illegal drugs. The introduction goes on to discuss some of the terms and concepts used in the book, such as 'abuse', 'dependence', 'harm reduction', 'polydrug use' and 'psychoactive drugs', and describes the legal implications of drug abuse. Chapter 2 deals with the injection of drugs and the dangers arising. Each of the next 17 chapters deals with a particular drug. Those covered include opioids, cannabis, cocaine, amphetamines, ecstasy, LSD, volatile substances, performance-enhancing drugs, over-the-counter and prescription medicines, plants and fungi, caffeine, nicotine and alcohol. These chapters give concise information under the following headings: history, effects sought, administration, pharmacology, adverse effects, dependence, interactions with medicines, use and concurrent illness, and pregnancy and breastfeeding.

Drugs of abuse has been comprehensively revised since the first edition, and includes new chapters on gamma hydroxybutyrate and on the internet as an information resource. Also covered are the prevalence of drug use, a detailed assessment of side effects, and interactions between illicit drugs and conventional medicines. The book is an accessible source of detailed information presented in a concise way. It will be of interest to healthcare professionals and those working with drug users in the community.



Alcohol and crime

Dingwall G
Willan Publishing 2006, 216 pp.
ISBN 1 84392 167 7 (hardback)

This book examines the nature of the connection between alcohol and crime, and the way the criminal justice system responds to those who offend after consuming alcohol. The author claims that much of the research in this area is narrow in focus. He draws on a wide range of sources and research findings, and sets the subject within a broader comparative context. He sets out to critically review this literature, consider the policy implications that arise from it, and suggest a principled approach to those involved in alcohol-related crime. *Alcohol and crime* will be useful reading for anybody concerned with the issue and its many social, legal and criminological ramifications.

The introductory chapter gives an overview of habits and patterns of alcohol consumption in the UK. The next two chapters consider the link between alcohol and crime: chapter 2 analyses a number of studies that have considered the extent to which offenders drink prior to offending; chapter 3 looks at the ways in which the consumption of alcohol may increase the likelihood of offending and concludes by considering some of the methodological problems that arise in trying to establish a causal link. Chapter 4 looks at ways of preventing and policing alcohol-related crime and disorder. The next two chapters give a detailed critique of the legal response to alcohol-induced offending: chapter 5 deals with substantive criminal liability; chapter 6 is concerned with sentencing. Chapter 7 concludes by considering the UK government's recent strategies to reduce alcohol-related crime and the disorder associated with it, and suggests areas that still need to be addressed.

Journal articles

The following abstracts are from a selection of articles relating to the drugs situation in Ireland and recently published in international journals.

Trends in medical student use of tobacco, alcohol and drugs in an Irish university, 1973–2002

Boland M, Fitzpatrick P, Scallan E, Daly L, Herity B, Horgan J and Bourke G
Drug and Alcohol Dependence 2005; 85(2): 123–128

Questionnaire surveys of medical students in an Irish university were carried out in 1973 (n = 765), 1990 (n = 522) and 2002 (n = 537). This research reports on changes in tobacco smoking, drinking and drug use in these three surveys. Among western students, the estimated prevalence of current smoking declined from 28.8% in 1973 to 15.3% in 1990 to 9.2% in 2002 ($p < 0.001$), falling in both males ($p < 0.001$) and females ($p < 0.01$). The percentage of ex-smokers rose from 5.9% to 15.1% between 1990 and 2002, corresponding to the decline in current smokers. The prevalence of current drinkers increased over the period, to 82.5% among western students in 2002 ($p < 0.05$); female drinking had increased steadily since 1973 ($p < 0.001$), and the overall proportion of CAGE-positive drinkers had risen since 1990 ($p < 0.001$). The mean weekly alcohol consumption had risen in both sexes since 1990 (from 14.3 to 19.4 units in males, $p < 0.01$; from 6.0 to 9.5 units in females, $p < 0.001$). Despite the decrease in smoking rates, the research showed an increase in alcohol and drug consumption between 1973 and 2002. Personal misuse of addictive substances by doctors may mean that doctors will

Recent publications *(continued)*

fail to take misuse by patients seriously. The need for preventative and ameliorative action during the medical school years is clear.

HIV infection among heroin users and area of residence

Long J, Keenan E, Grogan L, Mullen L, Barry J and Sinclair H
Irish Medical Journal 2006; 99(8): 230–233

The aim of this study was to develop a hypothesis to explain the link between HIV prevalence and area of residence. The study was conducted in two parts, using two existing data sources. In Part 1, the bloodborne viral test status and test results of a sample of clients attending treatment in December 2001 in two areas of Dublin, an inner city area (Dublin 8) and a suburban area (Dublin 24), were extracted from the Bloodborne Viral Status Dataset created by Grogan. In Part 2 the characteristics of heroin users seeking treatment for the first time at treatment services in their respective areas of residence, Dublin 8 or Dublin 24, between 1997 and 2000 were examined, using data from the National Drug Treatment Reporting System. A higher proportion of heroin users in Dublin 8 had HIV and hepatitis C than did their counterparts in Dublin 24. The analysis suggests that heroin users in Dublin 8 were more likely both to have ever used cocaine and to have used heroin daily than were those who lived in Dublin 24. Also, a higher proportion of injectors living in Dublin 8 used heroin and cocaine concurrently than did their counterparts in Dublin 24. In both samples, heroin users who lived in Dublin 8 were older than those who lived in Dublin 24. The findings led to a hypothesis: 'The risk of acquiring HIV is associated with area of residence and may be linked to cocaine use.'

Completeness and accuracy of the drug treatment reporting system in Dublin, Ireland

Kavanagh P, Long J and Barry J
Irish Journal of Medical Science 2006; 175(3): 52–56

The National Drug Treatment Reporting System (NDTRS) is the Irish treated drug misuse surveillance system. The aim of this study was to measure the completeness and accuracy of the NDTRS. The authors conducted a cross-sectional survey of clinical records and matching NDTRS reporting forms of a random sample of 520 clients attending four Dublin treatment centres. Using clients' clinical records as the gold standard, system completeness (proportion of sample reported to the NDTRS) and accuracy of selected variables (proportion of reported clients' information on the NDTRS that matched clinical record information) were measured; 452/520 (87%) selected records were retrieved. The NDTRS was only 61.1% complete (95% CI 56.5–65.5); completeness differed across treatment centres (21.8%–85.6%, $p<0.0001$) and was greater for new and returning clients than for continuing clients (81.7% versus 53.9% respectively, $p<0.0001$). Problems were identified with the accuracy of some key variables. Urgent actions have been taken to improve the completeness and accuracy of the reporting system.

International study of heavy drinking: attitudes and sociodemographic factors in university students

Dantzer C, Wardle J, Fuller R, Pampalone SZ and Steptoe A
Journal of American College Health 2006; 55(2): 83–89

The authors studied the prevalence of heavy drinking among students in 21 developed and developing countries, using an anonymous survey of 7,846 male and 9,892 female students aged 17 to 30 years. There were wide variations among countries in the prevalence of drinking, and the highest rates of heavy drinking (defined as 5 or more drinks for men and 4 or more drinks for women on at least 1 occasion over the past 2 weeks) were reported in Belgium, Colombia, Ireland, and Poland (men), and Ireland and England (women). Heavy drinking was associated with living away from home, having a wealthier family background, and having well-educated parents. Beliefs about the dangers to health of excessive consumption were negatively related to heavy drinking. Heavy drinking is a concern among students in several countries and is associated with greater affluence. Challenging beliefs concerning health risks is a crucial aspect of prevention in this population.

Volatile substance abuse: A review of findings in ESPAD 2003

Ives R
Drugs: education, prevention and policy 2006; 13(5): 441–449
This article analyses data relating to volatile substance abuse (VSA) from the Report on the 2003 European School Survey Project on Alcohol and other Drugs (ESPAD). ESPAD is a survey of 15–16-year-old students in 35 European countries, including Ireland. The survey asked: 'On how many occasions (if any) have you sniffed a substance (glue, aerosols, etc.) to get high?' The lifetime experience of VSA (i.e. whether they had ever tried VSA) among students in the 35 countries varied from 2% (in Romania) to 22% (in Greenland). In Ireland the figure was 18%, down from 22% at the time of the 1999 ESPAD survey.

The author notes that 'much VSA is experimental and many of those who try "sniffing" only do so once or twice'. As a result, lifetime prevalence

Recent publications *(continued)*

figures may be high while current use may be low. In Ireland, current use, i.e. 12-month prevalence, was 10%. The highest 12-month prevalence occurred in Greenland (16%). In Ireland, 30-day prevalence was 3%. The highest 30-day prevalence occurred in Cyprus and Croatia (6%). In Ireland, girls reported considerably higher lifetime misuse than boys (21% versus 14%). The author notes that students in Ireland were most likely to report that obtaining volatile substances was very or fairly easy, and suggests that the association between prevalence and availability needs to be investigated further.

Hepatitis C infection among injecting drug users in general practice: a cluster randomised controlled trial of clinical guidelines' implementation

Cullen W, Stanley J, Langton D, Kelly Y, Staines A and Bury G
British Journal of General Practice 2006; 56(532): 848–856

Hepatitis C is a common infection among injecting drug users and has important implications for general practice. Although several clinical guidelines concerning the infection have been published, their effectiveness has yet to be tested. The aim of this research was to assess the effectiveness of a general practice-based complex intervention to support the implementation of clinical guidelines for hepatitis C management among current or former drug users attending general practice. The study design used was a cluster randomised controlled trial in general practices in the Eastern Regional Health Authority area of Ireland.

Twenty-six practices were randomly allocated within strata to receive the intervention under study or to provide care as usual for a period of six months. There was screening for patients attending general practice for methadone maintenance treatment for hepatitis C and referral of anti-HCV antibody-positive patients to a specialist hepatology department for assessment. The research concluded that, at study completion, patients in the intervention group were significantly more likely to have been screened for hepatitis C than those in the control group, odds ratio adjusted for clustering 3.76 (95% confidence interval [CI] = 1.3 to 11.3) and this association remained significant after adjusting for other potentially confounding variables, using multiple logistic regression, with the odds ratio adjusted for clustering 4.53 (95% CI = 1.39 to 14.78). Although anti-HCV antibody-positive patients in the intervention group were more likely to have been referred to a hepatology clinic, this was not statistically significant (p = 0.06).

Early initiation of cannabis use: a cross-national European perspective

Kokkevi A, Nic Gabhainn S and Spyropoulou M
Journal of Adolescent Health 2006; 39(5): 712–9

This study examines the relationship of the early initiation of cannabis use with other high risk behaviours and with psychosocial and health-related correlates in 15-year-old adolescents in six European countries, including Ireland. This study reports data collected through anonymous questionnaires self-completed in classrooms in 2001–2002 as part of the Health Behaviour in School-aged Children (HBSC) survey. Using descriptive and multivariate analyses, differences between countries in age of first cannabis use and associations with health and related psychosocial variables were measured and assessed. The prevalence of lifetime and last-year cannabis use ranged from 30.7% and 27.5% respectively in the Czech Republic to 5.4% and 4.1% respectively in Greece. In Ireland, lifetime and last-year prevalence were 19.9% and 18.3% respectively. Age at first use was lower in the high-prevalence countries than in countries with lower prevalence. For 15-year-olds, frequent use of tobacco and alcohol and other risk behaviours were correlated with early (13–15 years old) and especially very early (≤ 13 years old) cannabis initiation. Early cannabis use was almost uniformly associated with higher odds of more frequent use of cannabis and other substances, and with a common set of other problems. The authors conclude that prevention of drug abuse must commence in pre-adolescence.

Tipping the balance? An Irish perspective on Anderson and Baumberg

Butler S
Drugs: education, prevention and policy 2006; 13(6): 493–497

This brief comment on Anderson and Baumberg's (2006) review of alcohol in Europe looks at this report from an Irish perspective, with a view to assessing its impact on the alcohol policy debate which has been a feature of Irish society over the past decade. It is argued that the review's empirical data and the accompanying policy recommendations are already broadly familiar to Irish stakeholders in the alcohol policy process, but that the provenance of this report, prepared for the European Commission, creates further potential to tip the balance of Irish alcohol policy in the public health direction espoused by its authors.

(Compiled by Joan Moore, Brigid Pike and Louise Farragher)

From *Drugnet Europe*

Drug strategies broadening in scope

Cited from Drugnet Europe *No. 56, October–December 2006*

An in-depth analysis of drug policy published by the EMCDDA this year alongside the 2006 *Annual report*, reveals that there are strong signs of a broadening of the scope of drug strategies to encompass licit addictive substances, such as alcohol, tobacco and medicines, as well as illicit drugs. Over two-thirds of the countries surveyed now either cite both types of substance explicitly in their drug policy documents or include links to licit substances in the context of prevention and treatment.

In his message launching the report, EMCDDA Director Wolfgang Götz referred to this as 'clearly a timely development when the multiple use of licit and/or illicit substances ('polydrug use') is becoming ever more visible within the European drug culture'. The EMCDDA currently faces the challenge of monitoring a much broader spectrum of substances than a decade ago and polydrug use presents big challenges to drug monitoring systems that traditionally have focused on the use of individual substances. 'Developing new methodologies to understand this pattern of drug use must be high on our future agenda', said the Director, 'if we are to meet the needs of the growing number of people whose problems stem from using a range of drugs'

Harm-reduction measures may be failing women

Cited from Drugnet Europe *No. 56, October–December 2006*

In all EU countries, more men than women die from drug overdose, with women accounting for between 7% and 35% of drug-related deaths, depending on the country. However the review points to 'notable differences' between the genders in drug-related death trends. While overdose deaths in the EU fell among males by around 30% between 2000 and 2003 (EU-15), the number of deaths reported among females fell by only 15% over the same period. This raises the question of whether harm-reduction measures targeted at high-risk drug users are impacting less on women than on men.

Concerns also surround the relatively high rates of HIV infection found among women who inject drugs. Female injecting drug users (IDUs) are more often involved in sex work and are more vulnerable to HIV infection. Recent data from studies of IDUs in nine EU countries showed HIV prevalence to be on average 13.6% among male IDUs and 21.5% among females. The EMCDDA warns that although, overall, more men inject drugs and die from using them, one cannot ignore the fact that female injectors may be at greater risk and harder to reach.

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). An electronic version of _Drugnet Europe_ is available on the EMCDDA website at www.emcdda.europa.eu

If you would like to receive a hard copy of the current or future issues of _Drugnet Europe_, please contact: Drug Misuse Research Division, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 676 1176 ext 127; Email: dmrd@hrb.ie

Upcoming events

(Compiled by Louise Farragher) Email: lfarragher@hrb.ie

January 2007

Managing the performance, safety and health risks of employee drug and alcohol use

Organised by/Contact: Anita Furlong, Conference Administrator, EAP Institute, 143 Barrack Street, Waterford, Ireland
Tel: +353(51)855733
Fax: + 353(51)879626
Email: anita@eapinstitute.com
www.eapinstitue.com

Thursday 18 January 2007
Venue: Ramada Viking Hotel, Waterford

Thursday 15 February 2007
Venue: Heritage Hotel, Portlaoise

Thursday 8 March 2007
Venue: Radisson Hotel, Galway

Information: The Safety, Health and Welfare at Work Act 2005 was signed into law in June 2005. The Act requires employees not to be under the influence of intoxicants (defined as drugs and alcohol) to the extent that they endanger their own or another person's safety at work. The purpose of this seminar is to outline the impact of drug impairment in the workforce and give practical guidance on the recognition and treatment of employees whose behaviour presents risks to themselves and others.

February 2007

9 February 2007
Children affected by alcohol

Venue: Brunei Gallery, Thornhaugh Street, London
Organised by/Contact: Adriana Fabin, NOFAS-UK, The National Organisation For Fetal Alcohol Syndrome-UK, 14-B Hoop Lane, London NW11 8JL.
Tel: +44 (0)20 8458 5951
Email: nofas-uk@midlantic.co.uk
www.nofas-uk.org

Information: As binge drinking among young women increases, society is facing increasing risks of children being born with lifelong alcohol related brain damage and a spectrum of alcohol related disabilities. Prenatal exposure to alcohol can cause: learning disabilities; hyperactivity; attention and memory deficits; inability to manage anger; difficulties with problem solving; and prenatal and postnatal growth deficiencies. This conference is a response to growing needs of people that care for and work with children and adults whose mental health was in some way affected by prenatal alcohol exposure.

28 February 2007
Dual Diagnosis and the Criminal Justice System

Venue: ORT House Conference Centre, London
Organised by/Contact: Henry Ledden, Events Marketing Assistant, Pavilion, Richmond House, Richmond Rd., Brighton, East Sussex BN2 3RL, UK
Tel: +44 (0)1273 666706
Fax: +44 (0)1273 625526
Email: henryl@pavpub.com
www.pavpub.com

Information: Workers from the mental health and substance misuse sectors are increasingly aware of people having co-existing mental health and substance misuse needs, particularly in the criminal justice system. There is an urgent need for joined up interventions between all partners and better liaison with community agencies. This conference will explore how clients with dual diagnosis are treated in different aspects of the criminal justice system, and identify areas of good practice. The day will be of interest to both managers and frontline workers and will include a strong practical element.

March 2007

12–16 March 2007
50th Session of Commission on Narcotic Drugs (CND)

Venue: Vienna, Austria
www.unodc.org

Information: The CND is the central policy-making body within the United Nations system dealing with drug-related matters. It analyses the world drug situation and develops proposals to strengthen the international drug control system to combat the world drug problem.

15–16 March 2007
2007 National Drug Treatment Conference

Venue: Novotel London West – Hotel and Convention Centre
Organised by/Contact: Exchangesupplies
Tel: +44 (0)1305 262244
www.exchangesupplies.org

Information: The National Drug Treatment Conference is an essential event for policy makers, commissioners, drug treatment workers and other health and social care professionals working with drug users. Four major themes will be addressed by the conference:

- Social exclusion, poverty and drugs
- Detox and aftercare
- Legal and political issues for drug treatment
- New treatments

Upcoming events *(continued)*

22–23 March 2007
First Annual Conference of the International Society for the Study of Drug Policy

Venue: P-Hotels Oslo, Grensen 19, NO-0159 Oslo, Norway
Registration: Online, by 16 February 2007
www.issdp.org

Information: The conference is being supported by the Nordic Council for Alcohol and Drug Research (NAD) with the Norwegian Institute for Alcohol and Drug Research (SIRUS) as local host. Participants are invited from a variety of disciplines and institutional backgrounds: universities, national and international agencies active in drug policy and independent research institutions. Practitioners who consider themselves consumers rather than producers of policy-relevant research will be particularly welcome. Four themes will be given particular emphasis: developing harm indexes for policy decision; estimating government expenditure on drug policy; modelling the effects of specific policies and programmes; and assessing the impact of harm reduction and substitution treatment initiatives.

May 2007

13–17 May 2007
Harm reduction – coming of age

Venue: Warsaw, Poland
Organised by/Contact: International Harm Reduction Association
Tel: +44 (0)208 123 99 81
Fax: +48 (0)22 640 82 71
Email: info@harmreduction2007.org

Information: This annual international conference is a key forum for the dissemination of harm reduction ideas and practice, attended by over 1,000 people from over 60 countries. It brings together frontline workers, researchers, policy makers, members of governments, officials from law enforcement, the judiciary, criminal justice workers, UN officials, members of national and international NGO's, together with members of drug user organisations.

June 2007

10–15 June 2007
International Council on Alcohol and Addictions 100th Birthday and 50th Annual Conference

Venue: Stockholm Conference Centre
www.icaaconference.se/

July 2007

7–12 July 2007
30th Annual Scientific Meeting of the Research Society on Alcoholism

Venue: Hyatt Regency, Chicago, USA
Organised by/Contact: Research Society on Alcoholism. Debra SHARP
Research Society on Alcoholism, Suite D-89, 7801 North Lamar Blvd.
Austin, TX 78752-1038 USA
Tel: +1(512) 454 0022
Fax: +1(512) 454 0812
DebbyRSA@sbcglobal.net

Information: The primary goal of the meeting is to provide a forum for alcohol researchers, from all disciplines, to present the latest findings and to learn about new research developments.

The Drug Misuse Research Division (DMRD) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug situation, its consequences and responses in Ireland. The DMRD maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The division also manages the National Documentation Centre on Drug Use. The DMRD disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland*, and other publications. Through its activities, the DMRD aims to inform policy and practice in relation to drug use.

***Drugnet Ireland* mailing list**
If you wish to have your name included on the mailing list for future issues of *Drugnet Ireland*, please send your contact details to:
Drug Misuse Research Division, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 676 1176 ext 127; Email: dmrd@hrb.ie

Please indicate whether you would also like to be included on the mailing list for *Drugnet Europe*.